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	09/18/2025

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 - Immediate jeopardy to resident health or safety 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** Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that a resident received adequate supervision for 1 of 1 resident reviewed who was able to successfully elope from the facility, Resident ID #15.Findings are as follows:Record review of a facility policy titled, Wandering and Elopements states in part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintain the least restrictive environment for residents.If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the residents' safety.If an employee observes a resident leaving the premises, he/she should.attempt to prevent the resident from leaving.get help from other staff members .inform charge nurse or director of nursing services.During a surveyor observation on 9/15/2025 at approximately 8:00 AM during the initial tour, revealed that the facility is equipped with a wander guard system which indicates that when a resident is wearing a wander guard device and attempts to exit the facility, an alarm will sound, alerting the staff.Record review revealed the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, mild neurocognitive disorder, dementia, and anxiety.Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 5 out of 15, indicating s/he has severely impaired cognition. Additional review of the MDS revealed the resident requires the use of a wheelchair for ambulation.Record review of a progress note dated 9/1/2025, states in part, .resident found self wheeling in the parking lot. [S/he] was brought back to the unit by activity staff. [S/he] is currently in the dining room and on 15-minute checks.Record review of an assessment titled, Interim Elopement/Wandering Risk Evaluation dated 9/2/2025, revealed that the resident was at risk for Wander/Elopement.Record review of the resident's care plan revealed a focus area initiated on 9/3/2025 which states in part, I am at actual/potential risk for elopement [related to] wandering, with an intervention to apply a wanderguard device.Record review of a physician's order dated 9/3/2025 which states, Wander Bracelet: Check Placement of Wander Bracelet on wheelchair on every shift.During a surveyor observation on 9/16/2025 at approximately 12:30 PM, the resident was observed self-propelling in the parking lot away from the front door. During this observation, there were no staff observed to be supervising the resident. Further observation revealed there was no wander guard located on the resident's wheelchair, per the physician's order.During a surveyor interview on 9/16/2025 at approximately 1:00 PM with Nursing Assistant (NA), Staff L, she revealed that the resident was participating in activities in the main dining room. When the surveyor informed Staff L that there were no residents in the main dining room, she proceeded to ask multiple staff where the resident was. She then exited the facility from the main entrance to look outside and found him/her in the parking lot. Staff L introduced the surveyor to the resident and immediately went back into the facility, leaving the resident outside without staff supervision. During a subsequent interview with Staff L at approximately 1:40 PM, she revealed that she was unaware that the resident had an order for a wander guard bracelet and should not be outside without supervision.Review of the September 2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Treatment Administration Record (TAR) revealed the physician's order to check the placement of the Wander Bracelet was documented as completed by Licensed Practical Nurse (LPN), Staff F, on the 7:00 AM to 3:00 PM shift on 9/16/2025, the day the resident was observed outside of the facility without his/her wander bracelet fastened to his/her wheelchair.During a surveyor interview on 9/16/2025 at approximately 2:00 PM with the Director of Nursing Services, she acknowledged that Resident ID #15 did not have a wander guard on his/her wheelchair and should not be outside unsupervised. Additionally, she could not provide evidence that the facility ensured that the resident received adequate supervision to prevent an elopement.During a surveyor interview with LPN, Staff F on 9/16/2025 at approximately 2:15 PM, she acknowledged signing off the order for the wander bracelet in the TAR as she had seen it attached to a wheelchair earlier in the day. However, she was unable to provide evidence that it was fastened to the wheelchair the resident was using at the time s/he exited the building.The facility's failure to provide adequate supervision and implement interventions for a cognitively impaired resident who is at risk for elopement and who has successfully eloped, placed him/her at risk for more than minimal harm, injury, impairment, or death.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and resident and staff interview, it has been determined that the facility failed to provide and prepare food in a form designed to meet individual needs for 2 of 4 residents reviewed with a physician's order for moderately thickened (honey) consistency fluids, Resident ID #s 49 and 19. Findings are as follows:Record review of the facility's diet manual states in part, .Thickened Liquids.Honey-like: Sticks to sides of a cup like honey. Pours very slowly, such as honey and cream soup.1. Record review revealed Resident ID #49 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, aspiration pneumonia (infection of the lungs caused by inhaling saliva, food, liquid, or vomit) and stroke.Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating s/he has severely impaired cognition. Additional review revealed that s/he was coughing or choking during meals and had complaints of difficulty with swallowing during the review period.Review of the care plan revealed a focus area initiated on 4/24/2025 indicating Resident ID #49 has a nutritional problem related to a swallowing issue which requires honey thickened fluids.Review of a physician's diet order dated 4/19/2025 revealed that Resident ID #49 requires honey thickened fluids.During a surveyor observation on 9/15/2025 at approximately 12:30 PM, Resident ID #49 was observed eating lunch in his/her room. S/he was observed picking up an 8-ounce (oz) mug of liquid off of the meal tray, which then spilled over the top of the mug along with a dry, white, powdery substance. S/he then proceeded to take a drink from the mug and immediately started coughing. The call light was immediately activated by the surveyor for staff assistance. Nursing Assistant (NA), Staff A, entered the room.During a surveyor interview immediately following the above observation with Staff A, she was unable to identify the consistency of the liquid provided to the resident to drink and requested to go ask the nurse. Staff A was observed mixing in the white, powdery substance as she brought the drink to Licensed Practical Nurse (LPN), Staff B to be observed. Staff B was asked by the surveyor what the consistency of the drink was, and she stated, I'm not sure, maybe nectar [mildly thickened fluid, a thinner consistency than honey thickened].Record review of a nursing progress note dated 9/15/2025 states, Resident observed coughing with nectar liquids at lunch. Liquids downgraded to pudding thickness [extremely thick fluids that hold their shape on a spoon and do not flow], speech eval [evaluation] requested with therapy team. Residents [family] made aware. Director of rehab aware and awaiting speech therapist eval at this time.Record review of a nursing progress note on 9/15/2025 states in part, .ordering a chest x-ray to rule out aspiration pneumonia.2. Record review revealed Resident ID #19 was admitted to the facility in May of 2023 with diagnoses including, but not limited to, dysphagia (difficulty swallowing), acute respiratory failure, and aspiration pneumonia.Review of an MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15, indicating moderately impaired cognition.Review of the care plan revealed a focus area initiated on 6/9/2025 indicating Resident ID #19 has a potential for aspiration due to dysphagia with an intervention to provide a therapeutic diet as ordered, including the prescribed fluid consistency.Review of a hospice recommendation dated 6/2/2025 revealed that Resident ID #19 had a recommendation approved by the physician that states, please downgrade elder to honey thick for reoccurring aspiration pneumonia.Review of a physician's diet order dated 6/9/2025 revealed that Resident ID #19 requires honey thickened fluids.During a surveyor observation and interview on 9/15/2025 at approximately 12:50 PM, Resident ID #19 was observed eating lunch in his/her room. S/he was observed with an 8 oz clear plastic cup with a lid and a tea bag inside.Immediately following the above observation, the surveyor went a retrieved LPN, Staff C. Staff C poured the liquid out of the cup and was noted to pour freely and did not appear to be honey thickened. At that time, Staff C revealed that the drink appeared thickened at the bottom, the liquid on (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	top was not, indicating it required mixing. She further revealed that the NAs prepare and thicken the drinks at bedside.Record review of a nursing progress note dated 9/15/2025 states, At approximately 12:50pm, resident observed with un-thickened fluid in mug near [him/her]. fluid removed, resident assessed with no visible signs of aspiration. lung sounds clear, will continue to monitor for any signs of aspiration x 72 hours. Fluid does not appear to have been consumed. monitoring ongoing.During a surveyor interview on 9/15/2025 at 12:58 PM with NA, Staff D, she revealed that she prepared the beverage for Resident ID #49 and mixed 1 packet of Thick & Easy into the mug of apple juice. Additionally, she indicated that when prepares the beverages for Resident ID #19, who also requires a honey thickened consistency liquid, she uses only a 1/2 packet of Thick & Easy. Furthermore, she did not know the number of fluid ounces contained in the beverage cups supplied by the facility, indicating she was unaware of how much thickening agent was required to achieve the desired consistency for Resident ID #s 19 and 49. Record review of a packet of thickener agent provided by the facility titled, THICK & EASY states in part, Directions: Add 1 packet.to 4fl oz of liquid. Stir with a spoon or fork for approximately 15 seconds or until thickener is dissolved. Allow 1-4 minutes for product to reach desired thickness.Honey-like Consistency: Add one packet to 4fl oz of liquid.During a surveyor interview on 9/15/2025 at 2:17 PM with the Director of Nursing Services, she revealed that she would expect the staff to prepare the beverages according to the prescribed orders and manufacturer's instructions.The facility's failure to provide and prepare foods in a form designed to meet individual needs for Resident ID #s 19 and 49 placed the residents at risk for more than minimal harm, impairment, injury, or death. Cross reference F 726.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, and resident and staff interviews, it has been determined that the facility failed to maintain a safe and clean environment relative to 3 of 3 nursing units observed and the main building.Findings are as follows:During a surveyor observation on 9/15/2025 at approximately 8:00 AM, upon entrance to the main building, the state agency survey team was met with a noticeable foul and unpleasant odor that smelled distinctly of urine.Multiple surveyor observations on 9/15/2025, during the state agency survey team's initial tour, revealed the following observations, on the following units:South Unit:-8:31 AM: room [ROOM NUMBER] had a strong, unpleasant odor consistent with urine.East Unit:-9:57 AM: room [ROOM NUMBER] had a strong, unpleasant odor consistent with urine.West Unit:-10:33 AM: room [ROOM NUMBER] had a strong, unpleasant odor consistent with urine. The resident was observed with a saturated bed comforter and clothing. Additionally, a brownish discoloration was noted on the white bed linen.-10:56 AM: room [ROOM NUMBER] had a strong, unpleasant odor consistent with urine. Additionally, the bed linens were noted to have a brownish discoloration and dried tan/yellow stains. Further, particles of food that resembled scrambled eggs were scattered on the comforter and bed linens while the resident remained in his/her bed.-11:16 AM: room [ROOM NUMBER] had a strong, unpleasant odor consistent with urine. Additionally, the resident was observed resting in his/her bed and was noted to have a dried, tan/yellow colored stain on his/her white bed linens.Surveyor interviews on 9/15/2025 at 10:38 AM and 11:31 AM with Licensed Practical Nurse, Staff F, she acknowledged the above observations on the [NAME] Unit. During a surveyor interview on 9/16/2025 at approximately 3:45 PM with a small group of residents following the conclusion of the Resident Council task, the surveyor asked if they noted any unpleasant odors within the building and/or on the units, one resident who resides on the [NAME] unit stated, Yeah, It smells like pee!Additional surveyor observations throughout the survey process from 9/15/2025 through 9/18/2025, strong and unpleasant odors were noted in the main building and on all three nursing units.During a surveyor interview on 9/18/2025 at approximately 9:00 AM with the Administrator, he was unable to provide evidence that the facility maintained a safe and clean environment relative to the main building and the three nursing units.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff and resident interviews, it has been determined that the facility failed to ensure that a resident's right to communication to promote a dignified existence was promoted for 1 of 1 resident reviewed whose primary language is [NAME], Resident ID #86. Additionally, the facility failed to ensure that a resident's right to a dignified existence was promoted for 4 of 4 residents observed with soiled bed linens, Resident ID #s 12, 26, 30, and 37.Findings are as follows:Review of the Facility's admission document last revised in 2021 states in part, .Resident rights.The resident has a right to be treated with respect and dignity.The resident has the right to receive notices orally.and in writing.in a format and a language he or she understands.The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide.Clean bed and bath linens that are in good condition.1. Record review revealed Resident ID #86 was admitted to the facility in December of 2021 with a diagnosis including, but not limited to, depression.Review of his/her care plan revealed a focus area dated 6/13/2023 indicating his/her primary language is [NAME].Additional review of the care plan revealed a focus area dated 3/11/2025 that indicated s/he is independent fulfilling his/her leisure time and will pursue personal interests with an intervention that includes to provide him/her with the daily chronicle.Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed, Section F - Preferences for Customary Routine and Activities was coded as Very important for him/her to have books, newspapers, and magazines to read.During a surveyor observation and simultaneous interview on 9/15/2025 at approximately 10:45 AM with the resident, s/he was observed seated in his/her room watching television. Additionally, a newsletter titled, THE DAILY CHRONICLE dated 9/15/2025 was observed on his/her bedside table, however, it was written in English. When questioned, the resident gestured to the surveyor that s/he speaks some English. Further, s/he indicated that s/he is unable to read the THE DAILY CHRONICLE newsletter and would like to receive it in his/her primary language.During an additional surveyor observation on 9/16/2025 at approximately 10:30 AM, the resident was noted to receive another newsletter of THE DAILY CHRONICLE dated 9/16/2025, in English.During a surveyor interview immediately following the above observation with Certified Medication Technician, Staff E, she acknowledged that the resident received THE DAILY CHRONICLE in English and indicated that she was unsure if the resident can read it.During a surveyor interview on 9/16/2025 at approximately 11:00 AM with the Life Enrichment Director, she revealed that the resident's primary language is [NAME] and would expect him/her to receive the newsletter in his/her primary language. During a surveyor interview on 9/18/2025 at approximately 12:30 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #86 received the newsletter in a language that s/he can understand to help promote a dignified existence.2a. Record review revealed Resident ID #30 was admitted to the facility in October of 2023 with diagnoses including, but not limited to, osteoarthritis and adult failure to thrive.Review of an admission MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Additionally, s/he is coded as dependent on staff for his/her activities of daily living (ADLs).During a surveyor observation and simultaneous interview on 9/15/2025 at approximately 8:31 AM, Resident ID #30 was observed lying in bed in his/her room. S/he revealed that s/he has been waiting for personal care for over an hour and is currently sitting in a puddle of piss. Additionally, s/he rolled to his/her side exposing the bed linens underneath him/her that revealed a tan/yellow stain and a strong odor of urine.2b. Record review revealed Resident ID #37 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, alcohol abuse and major depressive disorder.Review of an MDS assessment dated [DATE] revealed s/he is coded as dependent on staff for his/her (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADLs.Review of a care plan focus area dated 3/25/2024 revealed that s/he refuses care at times with an intervention that includes to return in 5-10 minutes if s/he refuses ADL care.During a surveyor observation on 9/15/2025 at approximately 10:36 AM, Resident ID #37 was observed lying in his/her bed. Additionally, an overpowering, unpleasant odor that smelled of urine was noted. Further observation revealed the resident's clothing and bed linens were noted to be saturated and there was a brown colored discoloration observed on the sheet beneath him/her.During a surveyor interview immediately following the above observation with Licensed Practical Nurse (LPN), Staff F, she acknowledged the above observation. She revealed that Resident ID #37 often refuses care, and she was present when the Nursing Assistant (NA), Staff G, attempted to provide ADL care around 7:30-8:00 AM and the resident refused.During an additional surveyor observation on 9/15/2025 at approximately 11:32 AM of the resident, approximately one hour after the surveyor's initial observation, the resident was observed lying in bed with all linens stripped except for the fitted sheet, in which a large tan/yellow stain was observed. Further, the edges of the stain appeared to have dried, and the center remained saturated.During a follow up surveyor interview on 9/15/2025 at approximately 11:48 AM with Staff F, she acknowledged the above observation and revealed that she spoke with Staff G who informed her that Resident ID #37's care had been completed.During a surveyor interview on 9/15/2025 at approximately 12:03 PM with Staff G, he revealed that he was assigned to care for Resident ID #37 on 9/15/2025 during the 7:00 AM - 3:00 PM shift. He revealed that he attempted to provide ADL care for the resident around breakfast time and s/he refused. He further revealed that at 11:30 AM, he reattempted to provide ADL care to the resident, and s/he complied. He was unable to provide evidence that he reattempted to complete ADL care for the resident after s/he initially refused until approximately three and a half hours later, after the resident initially refused.2c. Record review revealed Resident ID #12 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, morbid obesity and cognitive communication deficit.During a surveyor observation on 9/15/2025 at approximately 10:56 AM, Resident ID #12 was observed lying in his/her bed. Additionally, the bed linens were observed to have dried tan/yellow discolorations. Further, particles of food that resembled scrambled eggs were scattered on the comforter and bed linens while the resident remained in his/her bed.During a surveyor interview on 9/15/2025 at approximately 11:47 AM with LPN, Staff F, she acknowledged the above observation.2d. Record review revealed Resident ID #26 was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, dementia.During a surveyor observation on 9/15/2025 at approximately 11:16 AM, Resident ID #26 was observed lying in his/her bed. Additionally, the bed linens were observed to have dried tan/yellow discolorations, and a strong odor of urine was noted.Record review revealed that Resident ID #26's care had been documented as completed, on 9/15/2025 at 11:12 AM.During a surveyor interview on 9/15/2025 at approximately 11:32 AM with NA, Staff H, she acknowledged the above-mentioned observation. Additionally, she revealed that she was assigned to care for Resident ID #26 at that time. Further, she acknowledged that she documented that she had completed his/her care although it was not completed and revealed it is not her normal practice to document tasks as completed if they are not done.During a surveyor interview on 9/18/2025 at approximately 12:30 PM with the DNS, she revealed that sometimes the bed linens they provide to residents are clean but are stained. She further revealed that she would expect that staff would reattempt to provide ADL care to a resident that refuses every 5-10 minutes if that's what the care plan indicates. Additionally, she was unable to provide evidence that Resident ID #s 12, 26, 30, and 37 received timely assistance with ADL care and clean bed linens to promote a dignified existence.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and resident and staff interviews, it has been determined that the facility failed to provide the necessary services to a resident who is unable to carry out Activities of Daily Living (ADLs) relative to bathing and personal hygiene for 6 of 6 residents reviewed, Resident ID #s 30, 34, 41, 69, 73, and 75. Findings are as follows:1. Record review revealed Resident ID #30 was admitted to the facility in October of 2023 with diagnoses including, but not limited to, osteoarthritis and adult failure to thrive.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Additionally, s/he is coded as dependent on staff for his/her ADLs. During a surveyor interview on 9/15/2025 at approximately 8:31 AM with Resident ID #30, s/he revealed that s/he has been waiting for personal care for over an hour and is currently sitting in a puddle of piss. At this time, the resident rolled to his/her side to reveal a sheet noted with both dried and wet tan/yellow stains, a strong odor of urine was also noted. Additionally, s/he revealed that s/he is scheduled to receive a shower tomorrow on the 7:00 AM to 3:00 PM shift and s/he could not recall when they last received a shower. Further, the resident revealed that the facility staff provides his/her personal care while in their bed and only uses dry shampoo to wash his/her hair. Record review of a facility document titled, South Unit 3 CNA [Certified Nursing Assistant] Assignments sheet provided by the facility revealed, Resident ID #30 was to receive a shower every Tuesday on the 7:00 AM to 3:00 PM shift and every Friday on the 3:00 PM to 11:00 PM shift.During a surveyor observation and subsequent interview on Tuesday, 9/16/2025 at 3:12 PM with Resident ID #30, s/he appeared ungroomed with greasy hair and a strong odor of urine was noted. S/he revealed that s/he did not receive a shower that day which was their scheduled shower day.Record review failed to reveal evidence that Resident ID #30 received a shower on 9/16/2025, his/her scheduled shower day. Additionally, the record failed to reveal evidence that s/he was offered, received, and/or refused showers on his/her scheduled shower days.2. Record review revealed Resident ID #34 was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, legal blindness.Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15, indicating intact cognition.During a surveyor interview on 9/16/2025 at 2:36 PM with Resident ID #34, s/he revealed that they have only received two showers since July. Further, s/he indicated that the staff do not offer showers and only provide basic hygiene care in the room.Record review of the resident's shower schedule revealed s/he is to receive a shower every Wednesday, on the 7:00 AM to 3:00 PM shift.During a surveyor interview on 9/18/2025 at 11:30 AM with Resident ID #34, s/he revealed that s/he did not receive his/her scheduled shower on Wednesday, 9/17/2025.Record review failed to reveal evidence that Resident ID #34 received a shower on 9/17/2025, his/her scheduled shower day. Additionally, the record failed to reveal evidence that s/he was offered, received, and/or refused showers on his/her scheduled shower day.3. Record review revealed Resident ID #41 was admitted to the facility in May of 2024 with a diagnosis including, but not limited to, anxiety.Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15, indicating intact cognition. Additionally, s/he requires substantial assistance from staff for his/her ADLs.During a surveyor observation and subsequent interview on 9/17/2025 at 1:00 PM, with Resident ID #41, s/he was in bed, wearing a johnny. The resident revealed that s/he cannot remember the last time s/he received a shower. Additionally, s/he revealed that the staff have not provided personal care during the 7:00 AM to 3:00 PM shift. Record review of Resident ID #41's shower schedule revealed that s/he is to receive a shower twice a week, every Wednesday during the 7:00 AM to 3:00 PM shift, and every Saturday during the 3:00 PM to 11:00 PM shift. Record review failed to reveal evidence that Resident ID #41 received a shower on 9/17/2025, his/her scheduled shower day. Additionally, the record failed to reveal evidence that s/he was offered, received, and/or refused showers on his/her scheduled (continued on next page)

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Heritage Hills Nursing & Rehabilitation Center	80 Douglas Pike Smithfield, RI 02917

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower days.4. Record review revealed Resident ID #69 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, osteoarthritis.Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. Additionally, s/he requires substantial assistance from staff for ADLs and receiving showers is somewhat important to him/her.During a surveyor interview on 9/17/2025 at 1:00 PM, with Resident ID #69, s/he revealed that s/he has not received a shower at this facility since his/her admission in August. Additionally, s/he revealed that s/he had his/her brief changed but staff have not provided personal care during this shift. Record review of Resident ID #69's shower schedule revealed that s/he is to receive a shower once a week, every Monday during the 3:00 PM to 11:00 PM shift.Record review failed to reveal evidence that s/he was offered, received, and/or refused showers on his/her scheduled shower day.During a surveyor interview on 9/17/2025 at 1:08 PM with Licensed Practical Nurse, (LPN) Staff I, she revealed that morning care should have been completed for Resident ID #41, prior to 1:00 PM.5. Record review revealed Resident ID #73 was admitted to the facility in February of 2021 with a diagnosis including, but not limited to, osteoarthritis.Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. Additionally, s/he requires assistance from staff for ADLs.During a surveyor interview on 9/17/2025 at 1:14 PM, with Resident ID #73, s/he revealed that s/he had not been provided personal care during this shift. S/he further revealed that they came in to change his/her brief in the morning, but the staff did not wash him/her at that time.Record review of Resident ID #73's shower schedule revealed that s/he is to receive a shower twice a week, every Wednesday during the 7:00 AM to 3:00 PM shift and Saturday during the 3:00 PM to 11:00 PM shift.Record review failed to reveal evidence that s/he was offered, received, and/or refused showers on his/her scheduled shower days.During a surveyor interview on 9/17/2025 at 1:38 PM with NA, Staff J, she revealed that she was still trying to complete morning care for the residents on her assignment and would be completing Resident ID #73's morning care shortly. She further revealed that she had not completed any showers on the South Unit because they only have 3 NAs and would not have the time.6. Record review revealed Resident ID #75 was admitted to the facility in June of 2025 with a diagnosis including, but not limited to, Alzheimer's.Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 out of 15, indicating severely impaired cognition. Additionally, s/he requires substantial assistance from staff for ADLs.Record review of Resident ID #75's shower schedule revealed that s/he is to receive a shower once a week, every Wednesday during the 7:00 AM to 3:00 PM shift.Record review failed to reveal evidence that s/he was offered, received, and/or refused showers on his/her scheduled shower days.During a surveyor interview on Wednesday, 9/17/2025 at approximately 1:15 PM with LPN, Staff K, she revealed that no residents on the [NAME] Unit received showers on 9/17/2025 because they only had 3 NAs scheduled, and residents would only receive showers if there were 4 NAs scheduled to work.During a surveyor interview on 9/17/2025 at approximately 2:27 PM with the Director of Nursing Services, she revealed that residents should receive showers on their scheduled shower days. If a shower is missed or the resident refuses, the NA is expected to reattempt, and if unsuccessful, notify the nurse, who is expected to document that information in a progress note. Additionally, she revealed that staff should accommodate a resident who did not receive a shower on their scheduled shower day or if a resident requests an additional shower. Furthermore, she was unable to provide evidence that the above-mentioned residents were offered, received, and/or refused showers on their scheduled shower days.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and resident and staff interviews, it has been determined that the facility failed to have sufficient nursing staff to assure resident safety and attain the highest practicable, physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care relative to providing care and responding to each resident's basic and individual needs for 1 of 3 nursing units reviewed, the South Unit. Findings are as follows:Record review of the Facility Assessment States in part, Staffing Guidelines.Our staffing pattern is further developed based on the assessed nursing care needs of our residents, acuity [the severity of an illness], and census [unit population]. The base staffing pattern represents typical staffing based upon the average daily census of the facility. The facility adjusts staffing based upon multiple factors, including but not limited to, shifts in resident census, acuity, communicable disease outbreaks, and admission or discharge volume.Staffing assignments are determined by looking at both census and acuity of the residents.The staffing pattern fluctuates when it is determined that one unit or shift needs additional assistance.Our staffing process includes ensuring that resident needs are met in the face of challenges related to call outs or emergent situations.Review of the nursing schedule from 9/15/2025 to 9/17/2025 revealed a total of 3 Nursing Assistants (NA) scheduled to work on the South Unit with a total census of 30 residents.Review of the NA's assignments for the South Unit revealed a total of 14 residents who require Hoyer lifts (a device designed to assist caregivers in safely transferring individuals with limited mobility. It is commonly used in healthcare settings and nursing homes, allowing caregivers to move residents from one place to another, such as from a bed to a wheelchair, a bath, or a chair.). Further review of this document states, .Reminder: 1) you need 2 assists when using a Mechanical lift [Hoyer lift] .Review of an untitled document provided by the facility revealed that on the South Unit, 6 residents require assistance with meals.During a surveyor interview on 9/18/2025 at 9:10 AM with the Staffing Coordinator, she revealed that 3 NAs is the base staffing for the South Unit.During the resident council task completed on 9/16/2025 at approximately 2:00 PM, multiple residents complained about waiting for long periods of time for staff to respond to their call lights with an average wait time between 30 minutes to 1 hour. Additionally, one resident indicated it can take up to two hours.1A. Record review revealed Resident ID #30 was admitted to the facility in October of 2023 with diagnoses including, but not limited to, osteoarthritis and adult failure to thrive.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Additionally, s/he is coded as dependent on staff for his/her activities of daily living (ADLs).During a surveyor interview on 9/15/2025 at approximately 8:31 AM with Resident ID #30, s/he revealed that s/he has been waiting for personal care for over an hour and is currently sitting in a puddle of piss. At this time, the resident rolled to his/her side to reveal a sheet noted with both dried and wet tan/yellow stains, a strong odor of urine was also noted. Additionally, s/he revealed that s/he is scheduled to receive a shower every Tuesday, on the 7:00 AM to 3:00 PM shift and s/he could not recall when s/he last received a shower. Further, the resident revealed that the facility staff provides his/her personal care while in their bed and only uses dry shampoo to wash his/her hair. The resident also indicated, in the past s/he would receive two showers per week.Record review of a facility document titled, South Unit 3 CNA [certified nursing assistants] Assignments provided by the facility revealed that Resident ID #30 was to receive a shower every Tuesday on the 7:00 AM to 3:00 PM shift and every Friday on the 3:00 PM to 11:00 PM shift.During a surveyor observation and subsequent interview on 9/16/2025 at 3:12 PM with Resident ID #30 s/he appeared ungroomed, with greasy hair and a strong odor of urine. S/he revealed that s/he did not receive a shower that day, which was his/her scheduled shower day. Record review failed to reveal evidence that Resident ID (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#30 received a shower on 9/16/2025, his/her scheduled shower day. Additionally, the record failed to reveal evidence that s/he was offered, received, and/or refused showers on his/her scheduled shower days.1B. Record review revealed Resident ID #73 was admitted to the facility in February of 2021 with a diagnosis including, but not limited to, osteoarthritis.Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. Additionally, s/he requires assistance from staff for his/her activities of daily living.During a surveyor interview on 9/17/2025 at 1:14 PM, with Resident ID #73, s/he revealed that s/he had not been provided with personal care during this shift. S/he further revealed that they came in to change his/her brief in the morning, but the staff did not wash him/her at that time.Record review of Resident ID #73's shower schedule revealed that s/he is to receive a shower twice a week, every Wednesday during the 7:00 AM to 3:00 PM shift and every Saturday during the 3:00 PM to 11:00 PM shift.Record review failed to reveal evidence that s/he was offered, received, and/or refused a shower on his/her shower days.During a surveyor interview on 9/17/2025 at 1:38 PM with NA, Staff J, she revealed that she was still trying to complete morning care for the residents on her assignment and would be completing Resident ID #73's morning care shortly. She further revealed that she had not completed any showers today on the South Unit because they only have 3 NAs scheduled and would not have the time2. Record review revealed Resident ID #15 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, mild neurocognitive disorder, dementia, and anxiety.Record review revealed that Resident ID #15 was at risk for elopement.A surveyor observation on 9/16/2025 at 12:46 PM revealed, Resident ID #15 was self-propelling out in the parking lot without supervision.During a surveyor interview on 9/16/2025 at approximately 2:00 PM with the Director of Nursing Services, she acknowledged that Resident ID #15 did not have a wander guard on his/her wheelchair and should not be outside unsupervised. Record review failed to reveal evidence that the staffing pattern fluctuates when it is determined that one unit or shift needs additional assistance as evidenced by the failures above which indicates that residents were not being provided with personal care and supervision as the facility did not have sufficient staff coverage. Cross reference F-550, F-677, F-689, and F-838.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and staff interview, it has been determined that the facility failed to ensure that nursing staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity (the severity of an illness), and diagnoses of the facility's resident population in accordance with the facility assessment as required for 4 staff members observed, affecting Resident ID #s 4, 19, 46, and 49.Findings are as follows:1A. Record review of the facility's diet manual titled, Thickened Liquids states in part, .Honey-like: Sticks to sides of a cup like honey. Pours very slowly, such as honey and cream soup.Record review revealed Resident ID #49 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, aspiration pneumonia (infection of the lungs caused by inhaling saliva, food, liquid, or vomit) and stroke.Review of a physician's diet order dated 4/19/2025 revealed that Resident ID #49 requires honey thick fluids.During a surveyor observation on 9/15/2025 at approximately 12:30 PM, Resident ID #49 was observed eating lunch in his/her room. S/he was observed picking up an 8-ounce (oz) mug of liquid off his/her meal tray, when the liquid with a dry white powdery substance spilled over the top of the mug. S/he then proceed to take a drink from the mug and immediately started coughing. The call light was immediately activated by the surveyor for staff assistance. Nursing Assistant (NA), Staff A entered the room.During a surveyor interview immediately following the above observation with Staff A, she was unable to identify the consistency of the liquid provided to the resident. Staff A was observed mixing in the white powdery substance as she brought the drink to Licensed Practical Nurse (LPN), Staff B to be observed. Staff B was asked by the surveyor what consistency the drink was, and she stated, I'm not sure, maybe nectar.1B. Record review revealed Resident ID #19 was admitted to the facility in May of 2023 with diagnoses including, but not limited to, dysphagia (difficulty swallowing), acute respiratory failure, and aspiration pneumonia.Review of a physician's diet order dated 6/9/2025 revealed that Resident ID #19 requires honey thick fluid.During a surveyor observation and interview on 9/15/2025 at approximately 12:50 PM, Resident ID #19 was observed eating lunch in his/her room. S/he was observed with an 8 oz clear plastic cup with a lid and a tea bag inside. The liquid poured freely and did not appear to be thickened.Immediately following the above observation, the surveyor went a retrieved LPN, Staff C. Staff C poured the liquid out of the cup and was noted to pour freely and did not appear to be honey thickened. At that time, Staff C revealed that the drink appeared thickened at the bottom, the liquid on top was not, indicating it required mixing. She further revealed that the NAs prepare and thicken the drinks at bedside.During a surveyor interview on 9/15/2025 at 12:58 PM with NA, Staff D, she revealed that she prepared the beverage for Resident ID #49 and mixed 1 packet of Thick & Easy into the mug of apple juice. Additionally, she indicated that when she prepares the beverages for Resident ID #19, who also requires a honey thickened consistency liquid, she uses only a 1/2 packet of Thick & Easy. Furthermore, she did not know the number of fluid ounces contained in the beverage cups supplied by the facility, indicating she was unaware of how much thickening agent was required to achieve the desired consistency for Resident ID #s 19 and 49. Record review of a packet of the thickener agent provided by the facility titled, THICK & EASY states in part, Directions: Add 1 packet.to 4fl [fluid] oz of liquid. Stir with a spoon or fork for approximately 15 seconds or until thickener is dissolved. Allow 1-4 minutes for product to reach desired thickness.Honey-like Consistency: Add one packet to 4fl oz of liquid.During a surveyor interview on 9/15/2025 at 2:17 PM with Director of Nursing Services (DNS) she revealed that she would expect the staff to prepare the beverages according to the prescribed orders and manufacturer's instructions.2. Review of a facility policy titled, Administering Medications last revised in April of 2019, states in part, Medications are administered in a safe and timely manner, and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as prescribed.Record review revealed that Resident ID #4 was admitted to the facility in April of 2024 with diagnoses including, but not limited to, dementia and intellectual disabilities.2A. Record review revealed a physician's order for Biotene Dry Mouth/Throat Liquid (Mouthwash) give 15 milliliters (ml) three times a day for comfort measures/dry mouth.Review of the Biotene Dry Mouth Oral Rinse label revealed a warning label that states, Do not swallow.During the medication administration task on 9/17/2025 at approximately 8:50 AM with Certified Medication Technician (CMT), Staff G, he was observed administering medication to Resident ID #4, he was observed to put a straw into the medicine cup with the mouth wash. The resident drank and swallowed the mouth wash.During a surveyor interview immediately following the above observation with Staff G, he indicated that the resident was given the mouth wash to drink due to the resident's inability to swish and spit out the mouth wash.2B. Record review revealed a physician's order for Haloperidol Lactate (antipsychotic) Concentrate 2 milligrams/milliliters (mg)/(ml), administer 0.25 ml to equal 0.5 mg two times a day. During a surveyor observation on 9/17/2025 at approximately 8:50 AM of CMT, Staff G was preparing medications to administer to the resident; he utilized the dropper for the liquid Haloperidol and put two full droppers into a medicine cup to equal 10 mg. When questioned by the surveyor about the dose being administered, he poured half the liquid Haloperidol into a second medicine cup to equal 2.5 ml or 5 mg. When questioned a second time about the dose being administered, Staff G acknowledged that the dose measured was 2.5 ml and not 0.25 ml, as ordered. He then threw both cups away and went to get assistance from the nurse. During a surveyor observation on 9/17/2025 at approximately 9:10 AM of LPN, Staff I she was observed to utilize the dropper for the liquid Haloperidol and measure between 0 and 1 mg of the liquid. When questioned by the surveyor about the dose being administered, Staff I acknowledged that there was no line to accurately measure 0.5 mg on the dropper. At this time Staff I got a smaller syringe and accurately drew up the 0.25 ml to equal 0.5 mg, as ordered.During a surveyor interview on 9/17/2025 at approximately 10:00 AM with the DNS, she acknowledged that Resident ID #4 should not have been given a straw to drink mouthwash and acknowledged that the mouthwash should not be swallowed. Additionally, the DNS revealed that she would expect Staff G and Staff I to utilize the appropriate size syringe to measure an exact dose of liquid medication to ensure proper dosage. 3. Review of a policy titled, Assistance with Meals dated 3/2022 states in part, .All employees who provide resident assistance with meals will be trained and shall demonstrate competency.During the entrance conference on 9/15/2025 at 8:58 AM, with the Administrator and the DNS, it was revealed that the facility does not have a paid feeding assistant program.Record review revealed that Resident ID #46 was readmitted to the facility in February of 2025 with a diagnosis including, but not limited to, dysphagia (difficulty swallowing).Record review revealed the resident requires a pureed textured diet.Review of the care plan for Resident ID #46, dated 6/9/2023 revealed that the resident is at risk for aspiration (medical term for when a fluid or solid accidentally enters your windpipe and lungs), due to a diagnosis of dysphagia and a history of a choking episode while eating breakfast. S/he is therefore at risk for pneumonia, malnutrition and/or dehydration. Additionally, the care plan revealed that Resident ID #46 has been noted to pocket foods (holding food in his/her mouth without swallowing it, increasing his/her risk for choking or pneumonia).During a surveyor observation on 9/17/2025 at 8:19 AM, the Life Enrichment Director, was observed assisting Resident ID #46 with his/her breakfast meal. Additionally, the Life Enrichment Director revealed that she has not been in a role that would have trained her to assist with meals and has not attended a state approved training program.During a surveyor interview on 9/17/2025 at 8:56 AM with the Staff Development Coordinator, she revealed that the Life Enrichment Director has not completed a competency for feeding assistance.Review of the Life Enrichment Director's online training failed to reveal evidence of training related to feeding assistance.During a surveyor interview on 9/17/2025 at 9:45 AM with the DNS, she was unable to provide evidence that the Life Enrichment Director received state approved training in feeding assistance. Additionally, she revealed that she would expect staff to receive specialized training prior to assisting a resident with meals.During a surveyor interview on (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/18/2025 at 11:49 AM with the DNS, she was unable to provide evidence that the above-mentioned staff provided competent care to Resident ID #s 4, 19, 46, and 49.Cross reference F-726, F-805, and F-811

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and staff interview, it has been determined that the facility failed to implement the facility-wide assessment that is used to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.Findings are as follows:Record review of the facility's undated document Facility Assessment states in part, Staffing Guidelines.Our staffing pattern is further developed based on the assessed nursing care needs of our residents, acuity [the severity of an illness], and census [unit population]. The base staffing pattern represents typical staffing based upon the average daily census of the facility. The facility adjusts staffing based upon multiple factors, including but not limited to, shifts in resident census, acuity, communicable disease outbreaks, and admission or discharge volume.Staffing assignments are determined by looking at both census and acuity of the residents.The staffing pattern fluctuates when it is determined that one unit or shift needs additional assistance.Our staffing process includes ensuring that resident needs are met in the face of challenges related to call outs or emergent situations.1. During the resident council task completed on 9/16/2025 at approximately 2:00 PM, multiple residents complained about waiting long periods of time for staff to respond to their call lights, with an average wait time between 30 minutes to 1 hour. Additionally, one resident indicated it can take up to two hours. Further, the council complained about not receiving showers and/or care as needed, and the odor in the building, revealing it smelled like urine.Review of the staffing guidelines for the facility revealed there is a total of 9 Nursing Assistants (NA) on the 7:00 AM to 3:00 PM shift.Review of the nursing schedule from 9/15/2025 to 9/17/2025 revealed a total of 3 NAs scheduled to work on the South Unit, for a census of 30 residents, and 4 NAs to work on the [NAME] Unit, for a census of 40 residents.Review of the NAs' assignments for the South Unit revealed a total of 14 residents that require the use of a Hoyer lift (a mechanical lift requiring the use of two staff members to transfer a resident with limited mobility). Further review revealed 7 residents that requiring the use of a Hoyer are on one assignment.Review of an untitled document provided by the facility revealed that on the South Unit, 6 residents require assistance with meals.During surveyor observations from 9/15/2025 during the initial tour of the facility, multiple residents were noted to be in urine saturated sheets with dried, amber colored stains. Additionally, the observation revealed several residents appeared unkempt with food noted on their bedding.2. During the resident council task completed on 9/16/2025 at approximately 2:00 PM, the council complained about not receiving showers and/or care as needed.During a surveyor interview on 9/17/2025 at approximately 1:10 PM with Licensed Practical Nurse, Staff K, she revealed that no residents received a shower on the [NAME] Unit because they only have 3 NAs.During a surveyor observation and simultaneous interview on 9/17/2025 at 1:29 PM with NA, Staff N, she was observed providing morning care to a resident. Additionally, she revealed that the facility was short staffed.Surveyor observations from 9/15/2025 through 9/17/2025 failed to reveal evidence of residents receiving showers on the [NAME] and South Units.3. A surveyor observation on 9/16/2025 at 12:46 PM revealed, Resident ID #15 self-propelling out in the parking lot without supervision.Record review revealed that Resident ID #15 was at risk for elopement.During a surveyor interview on 9/16/2025 at approximately 2:00 PM with the Director of Nursing Services, she acknowledged that Resident ID #15 did not have a wander guard on his/her wheelchair and should not be outside unsupervised. During a surveyor interview on 9/17/2025 at 1:49 PM with the Director of Nursing Services (DNS), she was notified of the concerns related to the acuity of the residents and the staffing pattern.Review of the nursing staffing schedule on 9/18/2025, after the facility was notified (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the concerns regarding the residents' acuity levels, revealed 4 NAs were scheduled for the South and [NAME] Units.During surveyor observations of the [NAME] and South Units on 9/18/2025 revealed residents receiving showers and morning care. During a surveyor interview on 9/18/2025 at 11:49 AM with the DNS, she was unable to provide evidence that the staffing pattern was adjusted based on the needs of the residents according to the facility assessment, until after it was brought to the facility's attention by the surveyor. Cross reference F 550, F 677, F 725 and F 689.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and staff interview, it has been determined that the facility failed to implement and maintain an effective, comprehensive, data-driven, Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. Additionally, the facility failed to make a good faith attempt to correct the identified concerns of patient care relative to call lights being answered, incontinence care, and morning care being provided.Findings are as follows:Review of a facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program last revised in February 2020, states in part, This facility shall develop, implement, and maintain an ongoing, facility wide, data driven QAPI program that is focused on indicators of outcomes of care and quality of life for our residents.identifying and prioritizing quality deficiencies.developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.Review of a document titled, Quality Assurance Performance Improvement Action Plan initiated on 9/16/2024, revealed a problem that states, Surveyor identified one instance of a resident being saturated in urine in the morning, 4 instances of residents not being provided morning care until well after 12-2 PM and call bells not being answered timely.Further review revealed actions or interventions implemented as follows:- Reeducation was provided to facility leadership and scheduler to the sufficient nursing staff guidelines.- The facility assessment has been updated according to include a contingency plan for staffing.- Nursing staff re-educated to answer call lights timely and providing incontinent care before and after meals and as needed.- Audits will be completed to ensure timely incontinence care and morning care is being provided at a reasonable time.Review of the 2025 QAPI binder failed to reveal evidence that the QAPI committee discussed any of the above concerns after the January 2025 QAPI meeting.During a surveyor interview on 9/18/2025 at approximately 12:00 PM with the Administrator, he was unable to provide evidence of a good faith attempt to correct the identified concerns brought forth by the 2024 annual recertification survey and was unable to provide evidence of a comprehensive QAPI program that addressed the criteria to monitor nursing services and care concerns.Cross reference F 550, F 677, F 725, F 726, F 838 and F 919.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, surveyor observation, and staff interview it has been determined that the facility failed to provide care that meets professional standards for 1 of 1 resident reviewed with a Peripherally Inserted Central Catheter (PICC line, a thin tube inserted into a vein in the upper arm and advanced to a large vein near the heart to deliver long-term intravenous treatments), Resident ID #79 and for 1 of 3 residents observed for wound care, Resident ID #83.Findings are as follows:1. Review of a facility policy titled, Central Venous Catheter Flushing and Locking last revised 10/2024 states in part, .Flush the catheter and aspirate [the procedure of drawing blood or fluid the procedure of drawing blood or fluid] for blood return prior to each infusion to assess catheter function.Record review revealed that Resident ID #79 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, sepsis (a life-threatening medical condition that occurs when the body's response to an infection becomes dysregulated and causes widespread inflammation, leading to tissue damage, organ failure, and potentially death) and peripheral vascular disease.During a surveyor observation on 9/17/2025 at 9:26 AM, Licensed Practical Nurse, Staff F, flushed both lines of the resident's PICC line with normal saline but failed to aspirate for blood return. After flushing the lines, she infused an antibiotic through the line.During a surveyor interview immediately following the above observation with Staff F, she acknowledged that she did not aspirate for blood return and was unaware if it was the facility's policy.During a surveyor interview on 9/17/2025 at 9:52 AM with the Director of Nursing Services (DNS), she revealed that she would expect Staff F, to aspirate for blood return on a PICC line prior to administering medication per the facility policy.2. Record review revealed that Resident ID #83 was readmitted to the facility in February of 2025 with diagnoses including, but not limited to, multiple sclerosis and anxiety.According to, [NAME], et al. (2007). Skin adhesives and their role in wound dressings. https://wounds-uk.com, states in part, Tissue trauma caused by the removal of adhesive tapes and dressings is known to increase the size of wounds, exacerbate wound pain and delay healing.Record review revealed a physician's order to cleanse his/her coccyx with normal saline, pat dry, apply zinc, and a bordered gauze to the excoriation on his/her buttocks daily.During a surveyor observation on 9/16/2025 at 10:11 AM of LPN, Staff I, and the Assistant Director of Nursing, during wound care they cleansed the wound with normal saline, applied zinc and then covered with a bordered gauze. The bordered gauze did not cover the excoriation on Resident ID #83's buttocks and the adhesive was applied directly to the excoriated skin.During a surveyor interview directly following the above observation of wound care with Staff I, she acknowledged that she applied the bordered gauze to the excoriated skin on the resident's buttocks and acknowledged that she should not have.Record review revealed that the resident was evaluated by the wound physician on 9/17/2025 and the order was changed to omit the dressing.During a surveyor interview on 9/18/2025 at 12:44 PM with the DNS, she was unable to provide evidence that the facility provided care that meets professional standards relative to wound care for Resident ID #83.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 26 opportunities for errors observed during the medication administration task. Two errors occurred, resulting in an error rate of 7.69%, involving Resident ID #4.Findings are as follows:Review of a facility policy titled, Administering Medications last revised in April of 2019, states in part, Medications are administered in a safe and timely manner, and as prescribed.Record review revealed that the resident was admitted to the facility in April of 2024 with diagnoses including, but not limited to, dementia and intellectual disabilities.A. Record review revealed a physician's order for Biotene Dry Mouth/Throat Liquid (Mouthwash) give 15 milliliters (ml) three times a day for comfort measures/dry mouth.Review of the Biotene Dry Mouth Oral Rinse label revealed a warning label that states, Do not swallow.During a surveyor observation on 9/17/2025 at approximately 8:50 AM of Certified Medication Technician (CMT), Staff G, he was observed administering medications to Resident ID #4, he was observed to put a straw into the medicine cup with the mouth wash, and the resident swallowed the mouth wash.During a surveyor interview immediately following the above observation with Staff G, he indicated that the resident was given the mouth wash to drink, due to the resident's inability swish and spit out the mouth wash.During a surveyor interview on 9/17/2025 at approximately 10:00 AM with Licensed Practical Nurse (LPN), Staff I, she revealed that the resident is not able to swish and spit the mouth wash and it should be administered using a mouth swab.B. Record review revealed a physician's order for Haloperidol Lactate (antipsychotic) Concentrate 2 milligrams/milliliters (mg)/(ml), administer 0.25 ml to equal 0.5 mg two times a day. During a surveyor observation on 9/17/2025 at approximately 8:50 AM of CMT, Staff G was preparing medications to administer to the resident he utilized the dropper for the liquid Haloperidol and put two full droppers into a medicine cup to equal 10 mg. When questioned by the surveyor about the dose being administered, he poured half the liquid Haloperidol into a second medicine cup to equal 2.5 ml or 5 mg. When questioned a second time about the dose being administered, Staff G acknowledged that the dose measured was 2.5 ml and not 0.25 ml, as ordered. He then threw both cups away and went to get assistance from the nurse. During a surveyor observation on 9/17/2025 at approximately 9:10 AM of LPN, Staff I, she was observed to utilize the dropper for the liquid Haloperidol and measured between 0 and 1 mg of the liquid. When questioned by the surveyor about the dose being administered, Staff I, acknowledged that there was no line to accurately measure 0.5 mg on the dropper. At this time Staff I, got a smaller syringe and accurately drew up 0.25 ml to equal 0.5 mg, as ordered.During a surveyor interview on 9/17/2025 at approximately 10:00 AM with the Director of Nursing Services (DNS), she acknowledged that Resident ID #4 should not have been given a straw to drink the mouthwash. Additionally, the DNS revealed that she would expect Staff G and Staff I to utilize the appropriate size syringe to measure an exact dose of liquid medication. The DNS was unable to unable to provide evidence that the facility ensured each resident's medication regimen is free from a medication error rate of 5% or greater.Cross reference F 726

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that a resident with a known complicated feeding problem is assisted by a qualified staff member for 1 of 2 residents observed being assisted with feeding, Resident ID #46.Findings are as follows:Review of a policy titled, Assistance with Meals dated 3/2022 states in part, .All employees who provide resident assistance with meals will be trained and shall demonstrate competency.During the entrance conference on 9/15/2025 at 8:58 AM with the Administrator and the Director of Nursing Services (DNS), it was revealed that the facility does not have a paid feeding assistant program.Record review revealed that Resident ID #46 was readmitted to the facility in February of 2025 with a diagnosis including, but not limited to, dysphagia (difficulty swallowing). Record review revealed the resident requires a pureed textured diet.Review of the resident care plan dated 6/9/2023 revealed that the resident is at risk for aspiration (inhalation of something into the airway) due to a diagnosis of dysphagia and a history of a choking episode while eating breakfast. S/he is therefore at risk for pneumonia, malnutrition, and/or dehydration. Additionally, the care plan revealed that Resident ID #46 has been noted to pocket foods (holding food in his/her mouth without swallowing it, increasing his/her risk for choking or pneumonia).During a surveyor observation and simultaneous interview on 9/17/2025 at 8:19 AM with the Life Enrichment Director, she was observed assisting Resident ID #46 with his/her breakfast meal. Additionally, the Life Enrichment Director revealed that she has not been in a role that would have trained her to provide feeding assistance to residents and has not completed a state approved paid feeding assistant program.During a surveyor interview on 9/17/2025 at 8:56 AM with the Staff Development Coordinator, she revealed that the Life Enrichment Director has not completed a competency for feeding assistance.Review of the Life Enrichment Director's online training failed to reveal evidence of training related to feeding assistance.During a surveyor interview on 9/17/2025 at 9:45 AM with the DNS, she was unable to provide evidence that the Life Enrichment Director received state approved training for feeding assistance. Additionally, she revealed that she would expect staff to receive specialized training prior to assisting a resident with meals.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interview, it has been determined that the facility failed to explain the arbitration agreement to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands, for 2 of 12 residents reviewed for arbitration agreements, Resident ID #s 20 and 42.Findings are as follows:Review of a policy titled, Binding Arbitration Agreements last revised November 2023, states in part, .Upon admission, or any time during the resident's stay, the resident (or representative) may be presented with the opportunity to utilize a binding arbitration agreement to resolve disputes as long as the terms and conditions of the agreement comply with federal regulations.Binding arbitration agreements are voluntary for the residents. Residents are not compelled, pressured or coerced to enter into a binding arbitration agreement. It is unambiguously communicated to residents (or representatives) that binding arbitration agreements are optional and not required as a condition of admission or to receive care at this facility.The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a form and manner that he or she understands, taking into consideration the resident's (or representative's) language, literacy and stated preference for learning.A. Record review revealed Resident ID #20 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, stroke.Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.Review of a facility document titled, admission Packet, dated 8/26/2025 with an attachment titled, Alternative Dispute Resolution [ADR] Agreement Between Resident and Facility, revealed Resident ID #20 accepted and signed to enter into an arbitration agreement with the facility on 8/29/2025. Further review revealed a question which states, Facility representative has presented and explained the ADR to the Resident and/or Legal Representative, which was documented as No.During a surveyor interview on 9/17/2025 at 12:40 PM, with Resident ID #20, s/he revealed that s/he could not recall a facility representative explaining the arbitration agreement to him/her. Additionally, s/he was unaware that s/he had agreed to enter into a binding arbitration agreement with the facility and indicated that s/he would not have agreed to it.B. Record review revealed Resident ID #42 was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, legal blindness.Review of an MDS assessment dated [DATE], revealed a BIMS score of 15 out of 15, indicating intact cognition.Review of a document titled, admission Packet, dated 7/28/2025 with an attachment titled, Alternative Dispute Resolution Agreement Between Resident and Facility, revealed Resident ID #42 accepted and signed to enter into an arbitration agreement with the facility on 7/29/2025. Further review revealed a question which states, Facility representative has presented and explained the ADR to the Resident and / or Legal Representative, which was documented as No.During a surveyor interview on 9/17/2025 at 11:48 AM with Resident ID #42, s/he revealed that s/he could not recall a facility representative explaining the arbitration agreement to him/her. Additionally, s/he was unaware that s/he had agreed to enter into a binding arbitration agreement with the facility and indicated that s/he would not have agreed to it.During a surveyor interview on 9/17/2025 at 12:29 PM with the Admissions Director, she acknowledged that Resident ID #s 20 and 42's Alternative Dispute Resolution Agreement Between Resident and Facility forms documented that it was not explained to the residents. Further, she was unable to provide evidence that the facility explained the Alternative Dispute Resolution Agreement Between Resident and Facility, form to Resident ID #s 20 and 42, per policy and regulation, prior to both residents entering into a binding arbitration agreement.

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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. Based on record review, surveyor observation, and staff interview, it has been determined that the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident reviewed for contact precautions (use of gown and gloves upon room entry), Resident ID #79, and for 1 of 1 resident reviewed for a suprapubic catheter (a device inserted through the abdomen into the bladder to drain urine), Resident ID #47. Findings are as follows:1. Review of an undated facility policy titled, Clostridium Difficile [C. Diff, is a bacterium that can cause severe diarrhea] dated 10/2018, states in part, .Resident with diarrhea associated with C. Difficile.are placed on contact precautions.When caring for residents with [C.Diff], staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to [alcohol based hand sanitizer] for the mechanical removal of C.difficile spores from hands.Record review revealed that Resident ID #79 was readmitted to the facility in August of 2025 with a diagnosis including, but not limited to, C. Diff.Record review revealed a physician's order dated 8/19/2025 for contact precautions for C. Diff.Surveyor observations on all days of the survey from 9/15/2025 to 9/18/2025, revealed signage outside of the resident's room which stated in part, .CONTACT ENTERIC PRECAUTIONS.Clean hands with sanitizer when entering room and wash with soap and water upon leaving the room.gown and glove at door.A. A surveyor observation on 9/16/2025 at 5:12 PM with Registered Nurse, Staff M, revealed she exited the resident's room following care and failed to wash her hands with soap and water.During a surveyor interview immediately following the above observation with Staff M, she acknowledged that the signage posted outside of Resident ID #79's room indicated to wash her hands with soap and water upon exiting the room and acknowledged that she did not.B. During a surveyor observation on 9/17/2025 at 11:24 AM, during wound care, the Director of Nursing Services (DNS) entered the resident's room and closed his/her privacy curtain without putting on a gown or gloves prior to entering the resident's room or before having contact with the resident's environment.During a surveyor interview on 9/17/2025 at 12:02 PM with the DNS, she acknowledged that she entered the resident's room and closed his/her curtain without putting on a gown or gloves.During a surveyor interview on 9/17/2025 at 1:14 PM with the Infection Preventionist, she revealed that she would expect staff to follow the signage posted at the resident's door; to put on a gown and gloves prior to room entry and to wash their hands with soap and water upon exiting the resident's room.2. Review of a facility policy titled, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing dated 6/2014, states in part, .The purpose of this procedure is to provide guidelines for the prevention of catheter associated urinary tract infections (CAUTIs).Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor.Record review revealed that Resident ID #47 was readmitted to the facility in March of 2024 with diagnoses including, but not limited to, spastic quadriplegic cerebral palsy (a movement condition causes stiff muscles and involuntary muscle movements) and neuromuscular dysfunction of the bladder (a condition that causes the inability to control the bladder).Record review revealed that Resident ID #47 has a suprapubic catheter.During surveyor observations on 9/15/2025, the suprapubic catheter drainage bag was observed on the floor at the following times:-11:04 AM-2:17 PM-2:26 PMDuring a surveyor interview immediately following the 2:26 PM observation with Licensed Practical Nurse, Staff F, she acknowledged that the drainage bag was on the floor and indicated that it should be hung on the resident's bed.During a surveyor interview on 9/16/2025 at 1:39 PM with the Infection Preventionist, she revealed that she would expect the drainage bag to be off the floor.During a surveyor observation on 9/17/2025 at 12:22 PM, the resident's drainage bag was observed on the floor, after the concern was brought the facility's attention.During a surveyor interview on 9/18/2025 at 11:30 AM with the DNS, she revealed that she would expect the drainage bag to be hung on the resident's bed frame and not resting on the floor.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on surveyor observation, record review, and resident and staff interview, it has been determined that the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 3 units observed, the [NAME] Unit.Findings are as follows:Review of a facility policy titled, Answering the Call Light last revised 9/2022 states in part, .The purpose of this procedure is to ensure timely responses to the resident's requests and needs.During the resident council task completed on 9/16/2025 at approximately 2:00 PM, multiple residents complained about waiting for long periods of time for staff to respond to their call lights with an average wait time between 30 minutes to 1 hour. Additionally, one resident indicated it can take up to two hours.A surveyor observation on 9/17/2025 at approximately 9:25 AM of the [NAME] Unit, revealed two monitors at the Nursing Station. Additionally, the monitors were noted to be powered off.During a surveyor interview on 9/17/2025 at 9:37 AM with Licensed Practical Nurse (LPN), Staff I, she revealed that staff does not utilize any equipment that communicates a resident's call light alert directly to their person. Additionally, she acknowledged that the call lights do not call directly to a staff member or to a centralized staff work area.During a surveyor interview on 9/17/2025 at 9:41 AM with the Assistant Director of Nursing Services, she acknowledged that both monitors were powered off. She revealed that the monitors are broken, and that maintenance is aware of the problem and addressing it.During a surveyor interview on 9/17/2025 at 2:06 PM with the Maintenance Director, he revealed that the monitors needed repair, and he was unaware until it was brought to his attention by the surveyor.During a surveyor interview on 9/18/2025 at approximately 9:00 AM with the Administrator, he was unable to provide evidence that the call lights on the [NAME] Unit communicate the calls directly to a staff member or to a centralized staff work area, per the regulation.