

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Hebert Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 180 Log Road Smithfield, RI 02917	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that residents receive adequate supervision to prevent an accident for 1 of 3 residents reviewed for elopement, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy titled Elopement states in part, .Elopement- leaving the facility without permission and/or notification to the facility .Assessment: An assessment will be completed within 24-hours of admission.</p> <ol style="list-style-type: none"> 1. A determination of residents at risk will be made through the assessment process, observation and information received from other sources, such as family and medical records 2. A re-assessment will be completed for any resident who demonstrates any of the following . 3. A resident assess to be at risk. The following actions may be employed: <ol style="list-style-type: none"> 1. Application of a wanderguard [a system used to prevent residents with a tendency to wander from leaving monitored areas. It consists of wearable bracelets for residents, door sensors] 2. Initiation of frequent checks 3. Room transfer to a secured area 4. Residents at risk for elopement identified to appropriate staff 5. Facility transfer to a more suitable health care provider . <p>Surveyor observation on 7/15/2024 at approximately 12:00 PM revealed the facility is equipped with a wander guard system. When a resident is wearing a wander guard bracelet attempts to leave the facility, an alarm will go off alerting the staff.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed the resident was admitted to the facility in May of 2024 with diagnoses including, but not limited to, dementia, Wernicke's encephalopathy (a brain and memory disorder due to a lack of vitamin B1 that can cause confusion and memory loss), and traumatic brain injury.</p> <p>Record review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 10 out of 15, indicating s/he has moderately impaired cognition.</p> <p>Record review of a Wandering Risk assessment dated [DATE], indicated the resident was at a moderate risk for wandering.</p> <p>Additional record review failed to reveal evidence of interventions to prevent the resident from wandering after s/he was assessed to be a moderate risk for wandering.</p> <p>Record review of a subsequent Wandering Risk assessment dated [DATE], found the resident to be at a low risk for wandering as it was not completed in its entirety. The assessment failed to identify the cognitive orientation of the resident, any behaviors/mood the resident may exhibit and any antipsychotics, antidepressants, anti-anxiety/hypnotics, narcotic medications that the resident is taking. If this assessment had been completed in its entirety, the resident would have remained at a moderate risk for elopement.</p> <p>Review of a facility reported incident sent to the Rhode Island Department of Health on 7/14/2024, revealed that on 7/14/2024 the facility staff reported that Resident ID #1 eloped. At approximately 10:45 AM, a police officer arrived at the facility and informed the facility staff they had found Resident ID #1 and s/he was being transported to the hospital.</p> <p>Record review of a police report titled Incident Report revealed that the local police department was notified at 10:05 AM on 7/14/2024 by a member of the community that a person who appeared to be confused, was laying in the roadway. I responded to [facility] and advised the weekend nursing supervisor of the incident [facility nurse] advised [Resident ID #1] is a dementia patient at the facility.</p> <p>Record review of a hospital document dated 7/14/2024, titled emergency room VISIT NOTES revealed that Resident ID #1 was brought to the hospital by rescue after s/he was found sleeping on the roadway wearing unseasonably heavy clothing and sweating profusely. Additionally, the report revealed that s/he was not sure where s/he was or what happened.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff A, on 7/16/2024 at 9:02 AM, he revealed that the last time facility staff had seen the resident on the morning of 7/14/2024, prior to his/her elopement was at approximately 9:00 AM, when s/he was observed sitting on a chair outside of the facility to the left of the entrance door.</p> <p>During a surveyor interview with the Smoking Attendant on 7/15/2024 at 1:35 PM, she revealed that Resident ID #1 was a smoker and required supervision with smoking. She indicated she typically holds the materials for the residents that smoke, supervise the residents while they are smoking, and assists any residents that require help with lighting their cigarettes. Additionally, she indicated that she does not supervise the residents when they are not in the smoking area. Furthermore, she stated that she does not monitor the comings and goings of residents who ambulate to and from the smoking area independently.</p> <p>(continued on next page)</p>		

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