STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415049	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hebert Nursing Home	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46338 Based on record review, resident, and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 1 resident reviewed relative to a missed medication administration, Resident ID #2. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 3/10/2025 alleges that the resident has not received his/her Bictegravir-Emtricitabine-Tenofovir (BIKTARVY: a medication prescribed to treat, human immunodeficiency virus disease: HIV). Review of the manufacturer guidelines for Bictegravir-Emtricitabine-Tenofovir's states in part, .Inform patients that it is important to take BIKTARVY on a regular dosing schedule with or without food and to avoid missing doses as it can result in development of resistance . Record review revealed the resident was admitted to the facility in March of 2025 with diagnoses including, but not limited to, HIV and dialysis dependence (a life-sustaining treatment that is used to remove waste products and excess fluid from the blood when a person's kidneys are no longer functioning). Record review revealed a physician's order for Bictegravir-Emtricitabine-Tenofovir oral tablet 50-200-25 milligram (MG), 1 tablet by mouth one time a day to start on 3/6/2025. Review of the Electronic Medication Administration Record (EMAR) for March 2025 failed to reveal evidence that the resident received the above-mentioned medication on the following dates: - 3/6/2025 AM - 3/7/2025 AM - 3/8/2025 AM - 3/9/2025 AM (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress notes dated 3/8/2025 and 3/9/2025, authored by Registered Nurse, Staff A, revealed that the resident's family is expected to bring the BIKTARVY to the facility. Additional review of the progress note dated 3/9/2025 at 7:38 PM authored by Licensed Practical Nurse (LPN), Staff B, revealed that there was a filled prescription bottle of the medication waiting for pick up at the resident's community pharmacy. During a surveyor interview on 3/11/2025 at 1:53 PM with the resident, s/he acknowledged that s/he did not receive the BIKTARVY for 4 days and indicated that s/he was made aware by a nurse at the facility that the medication was not available. Additionally, the resident indicated that s/he informed the facility that the BIKTARVY should not be missed. Further, the resident indicated that s/he had made a call to a family member to bring this medication from home however, it was not brought in. During a surveyor interview on 3/11/2025 at 2:10 PM with Staff A, he acknowledged that the resident did not receive the BIKTARVY on 3/6, 3/7, 3/8 and 3/9/2025, as ordered. Additionally, Staff A revealed that when he notified the Director of Nursing Services (DNS) and the Administrator on 3/6/2025 that the BIKTARVY was not available, he was told to call the resident's family to bring it from home. During a surveyor interview on 3/11/2025 at 2:45 PM with LPN, Staff B, she indicated that when she notified the Administrator about the resident's medication, she was told that there was an agreement for the medication to be brought from home. Additionally, Staff B revealed that after speaking to the resident, she contacted his/her community pharmacy where a filled prescription was ready to be picked up. During a surveyor interview on 3/11/2025 at 3:09 PM with the Administrator, she acknowledged that the resident was not administered his/her doses of BIKTARVY on 3/6, 3/7, 3/8 and 3/9/2025 because a family member was supposed to bring it from home. Additionally, she indicated that there was an agreement between the facility and the hospital case manager prior to the resident's admission to the facility that the family will be providing the medication. Further, the Administrator was unable to provide evidence of this agreement. During a surveyor interview on 3/11/2025 at 3:30 PM with the DNS, she acknowledged that the resident did not receive his/her BIKTARVY on 3/6, 3/7, 3/8 and 3/9/2025. Additionally, she was unable to provide evidence of an agreement. During a surveyor interview on 3/11/2025 at approximately 5:00 PM with the Medical Director, he indicated that on 3/6/2025, he was made aware that the resident's madication is not available for administration because the facility was waiting for the family member to bring it in. Additionally, the Medical Director indicated that he was not aware that the resident missed the medication from 3/7, 3/8 and 3/9/2025.