

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 11/25/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, it has been determined that the facility failed to keep a resident free from abuse for 1 of 1 resident reviewed, Resident ID #2. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 10/8/2025, revealed in part, that a Nursing Assistant (NA), Staff C was witnessed talking to Resident ID #2 telling her how pretty and sexy s/he was. Staff C, then proceeded to lift up her shirt and show the resident that she too is sexy. This incident was witnessed by NA, Staff D and reported to the Director of Nursing Services (DNS). Review of a facility policy titled, Abuse prohibition states in part, .It is the policy of this facility to identify abuse, neglect, and exploitation of residents .This includes but is not limited to identifying and understanding the different types of abuse and possible indicators .The resident has the right to be free from abuse .Sexual abuse is non-consensual sexual contact of any type with a resident, as defined at have the capacity to consent. Sexual abuse includes, but is not limited to .Unwanted intimate touching of any kind especially of breasts or perineal area .Generally, sexual contact is nonconsensual if the resident either .appears to want to contact to occur, but lacks the cognitive ability to consent; or .does not want the contact to occur .Record review revealed that Resident ID #2, the alleged victim, was admitted to the facility in August of 2019 with diagnoses including, but not limited to, bipolar disorder, anxiety, and adjustment disorder. Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the resident's cognition is intact. During a surveyor interview on 11/17/2025 at 10:22 AM with Resident ID #2, s/he revealed that s/he had no recollection of the incident. Surveyor telephone interviews with Staff C were attempted on 11/17/2025 at 10:33 AM and 11/18/2025 at 9:57 AM, however, she did not answer and has not returned the surveyor's calls. Record review of the facility investigation revealed that at approximately 12:35 PM it was reported that an agency Nursing Assistant, Staff C went into Resident ID #2's room and proceeded to make small talk by telling [the resident] how pretty and sexy [s/he] was. [Staff C] then proceeded to lift her top and show [the resident] that she too is sexy. This was witnessed by Nursing Assistant, Staff D who immediately reported the incident. Staff C was interviewed in the presence of the Administrator and removed from the facility after she admitted to the inappropriate act and provided a statement. Record review of a statement dated 10/7/2025 authored by Staff C states, On [DATE]:45 PM, I entered the patient room and was inappropriate by exposing my top chest keeping my sport bra on. Record review of a statement dated 10/7/2025 authored by Staff D states, Today Tuesday October 7 an agency [nursing assistant] came to work with me. While I was doing [Resident ID #2] she came into the room talking about [him/her] nationality. she then told [the resident] that [s/he] dresses .nice and sexy. Suddenly she lifted her top up showing her bra and stomach, showing how sexy she was too. Record review of a facility document titled, Results of Investigation revealed that Resident ID #2 was interviewed in the presence of the Social Worker and the Administrator and reports that Staff C is .crazy and doesn't belong here. Additionally, the report revealed that the facility apologized to the resident and reassured him/her that Staff C will not be returning to the facility. During a surveyor interview on 11/18/2025 at 2:28 PM, with the DNS revealed that Staff C was added to a Do Not Return list and reported to the State Licensing Department and Agency that she was employed by. Additionally, she was unable to provide evidence that the facility kept Resident ID #2 free from sexual abuse.</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on record review and staff interview it has been determined that the facility failed to ensure nursing staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being of each resident, as determined by resident assessments and individual plans of care, for 1 of 1 resident reviewed for significant medication errors, Resident ID #1. The failure of the facility to ensure that nursing staff followed established medication administration protocols, adhered to scope-of-practice requirements, and maintained safe medication-handling practices resulted in significant medication errors. This failure contributed to the resident receiving multiple medications not prescribed to him/her, requiring emergency intervention and a hospital transfer. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 11/17/2025 alleged that Resident ID #1 was administered the wrong medications and arrived at the hospital lethargic and minimally responsive to painful stimuli. Additionally, the resident immediately required activated charcoal (a medication used to treat an overdose).Further record review revealed that the resident received the following medications that were prescribed to another resident:10 milligrams (mg) of Diazepam (a benzodiazepine, a medication that is prescribed to slow down the activity in your brain and nervous system)10 mg of Oxycotin Extended Release (a Scheduled II narcotic prescribed to treat pain)5 mg of Oxycodone (a Scheduled II narcotic prescribed to treat pain)10 mg of Cyclobenzaprine (a medication prescribed to relax muscles)50 mg of Lyrica (an anticonvulsant, a medication prescribed to treat nerve pain)1200 mg of Gabapentin (an anticonvulsant prescribed to treat nerve pain)200 mg of Acyclovir (an anti-viral medication)10 mg of Cetirizine (an antihistamine)800 mg of Ibuprofen25 mg of Januvia (an oral diabetic medication)25 mg of Jardiance (an oral diabetic medication)450 mg of Lithium (an antimanic prescribed to treat bipolar disorder)1000 mg of Metformin Extended Release (an oral diabetic medication)20 mg of omeprazole (a medication prescribed to treat acid reflux)According to the State Operation Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 7/23/2025 states in part, .To assure that all nursing staff possess the competencies, and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being .According to the state regulations for Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs (216-RICR-40-05-22), which states in part, .Medication aides are not allowed to administer the following kinds of medications: a. Schedule II controlled substances.Record review revealed Resident ID #1 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, heart failure, intellectual disabilities, and chronic obstructive pulmonary disease.Record review revealed that Resident ID #2 was admitted to the facility in August of 2019 with diagnoses including, but not limited to, bipolar disorder, anxiety, and adjustment disorder.Review of a nursing progress note dated 11/16/2025 revealed that the resident appeared lethargic at 10:45 AM. An assessment was completed and revealed that Resident ID #1 was unresponsive with pinpoint pupils. S/he required two emergency doses of 4 mg of Narcan, and Emergency Medical Services (EMS) were called to transport to the resident to the hospital.Review of a medication error screening tool provided by the facility revealed that on 11/16/2025, the Certified Medication Technician (CMT), Staff A, administered the wrong medication to Resident ID #1. The report further revealed that the wrong medications were given to the wrong resident. The medications administered to Resident ID #1 in error included: narcotics, anticonvulsants, antipsychotics, antidiabetics, antidepressants, muscle relaxants and vitamins.Record review of an undated written statement authored by CMT, Staff A, revealed that on the morning of 11/16/2025 she was preparing medications when the nurse gave her a cup of medications to administer to Resident ID #2. When she went into Resident ID #2's room s/he was sleeping. She then placed the prepared cup of medications for Resident ID #2 in the drawer of the medication cart and started to prepare Resident ID #1's medications. She revealed at this time she was distracted and placed Resident ID #1's medication cup down to assist another resident. When she returned, she retrieved Resident ID #2's medications and administered them to Resident ID #1 in error. Record review of a written statement dated 11/16/2025 authored by Registered Nurse, Staff B, revealed that on the morning of 11/16/2025 she signed off narcotics for Resident ID #2 and then gave them to the CMT to administer. She then indicated the medications were subsequently given to Resident ID #1 by Staff A. Resident ID #1 was observed in his/her wheelchair with ninnpoint pupils, lethargic and unresponsive. She administered two emergency doses of</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from significant medication errors for 1 of 1 resident reviewed who was administered an antipsychotic, antidiabetic agents, benzodiazepines (medications that are prescribed to slow down activity in your brain and nervous system), and narcotic medications that were prescribed for another resident, who required Emergency Medical Services (EMS), hospitalization, multiple doses of Narcan (a medication used to treat an opioid overdose) administration, and activated charcoal (a medication used to treat an overdose). These emergency interventions were necessary as a result of the medication errors involving Resident ID #1. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 11/17/2025 alleged that Resident ID #1 was administered the wrong medications and arrived at the hospital lethargic and minimally responsive to painful stimuli. Additionally, the resident immediately required activated charcoal. Further record review revealed that the resident received the following incorrect medications:10 milligrams (mg) of Diazepam (a benzodiazepine, a medication that is prescribed to slow down the activity in your brain and nervous system)10 mg of Oxycodone Extended Release (a Scheduled II narcotic prescribed to treat pain)5 mg of Oxycodone (a Scheduled II narcotic prescribed to treat pain)10 mg of Cyclobenzaprine (a medication prescribed to relax muscles)50 mg of Lyrica (an anticonvulsant, a medication prescribed to treat nerve pain)1200 mg of Gabapentin (an anticonvulsant prescribed to treat nerve pain)200 mg of Acyclovir (an anti-viral medication)10 mg of Cetirizine (an antihistamine)800 mg of Ibuprofen25 mg of Januvia (an oral diabetic medication)25 mg of Jardiance (an oral diabetic medication)450 mg of Lithium (an antimanic prescribed to treat bipolar disorder)1000 mg of Metformin Extended Release (an oral diabetic medication)20 mg of Omeprazole (a medication prescribed to treat acid reflux)Record review of an undated facility policy titled, General Dose Preparation and Medication Administration, states in part, .Prior to administration of medication, Facility staff should take all measures required.but not limited to the following .Verify each time a medication is administered that it is the correct medication, at the correct dose .for the correct resident .Identify the resident .According to the state regulations for Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs (216-RICR-40-05-22), which states in part, .Medication aides are not allowed to administer the following kinds of medications: a. Schedule II controlled substances.Record review revealed Resident ID #1 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, heart failure, intellectual disabilities, and chronic obstruction pulmonary disease.Record review revealed that Resident ID #2 was admitted to the facility in August of 2019 with diagnoses including, but not limited to, bipolar disorder, anxiety, and adjustment disorder.Review of a nursing progress note dated 11/16/2025 revealed that the resident appeared lethargic at 10:45 AM. An assessment was completed which revealed that s/he was unresponsive with pinpoint pupils. The resident required two emergency doses of 4 mg of Narcan, and EMS were called to transport to the resident to the hospital.Review of a nursing progress note dated 11/17/2025 revealed that the resident was admitted to the hospital with a diagnosis of an accidental overdose.Record review of an undated written statement authored by, Certified Medication Staff A, revealed that on the morning of 11/16/2025 she was preparing medications for Resident ID #2 when the nurse gave her additional medications to give. When she went into the resident's room s/he was sleeping. She then placed the prepared cup of medications in the drawer of the medication cart and started to prepare Resident ID #2's medications. She revealed that she was distracted and placed the cup down to assist another resident. When she returned, she retrieved Resident ID #2's medications and gave them to Resident ID #1. Record review of a written statement dated 11/16/2025 authored by Registered Nurse, Staff B, revealed that on the morning of 11/16/2025, she gave narcotics prescribed for Resident ID #2 and gave them to Staff A to administer. Staff A then subsequently gave Resident ID #2's medications to Resident ID #1 in error. Resident ID #1 was observed in his/her wheelchair, lethargic, unresponsive with pinpoint pupils. She administered two emergency doses of Narcan and called EMS.During a surveyor interview on 11/17/2025 at 2:04 PM with Staff A, she revealed that on 11/16/2025 during the morning medication pass she was distracted and inadvertently gave Resident ID #1 another resident's medications. She further revealed, the medications included Scheduled II narcotics that Staff B had given to her to administer to another resident. Additionally, she confirmed that the medications that were signed off by her in Resident ID #2's Medication Administration Record (MAR) on 11/16/2025 were given to Resident ID #1 in error. She acknowledged that she should not</p>		