

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  10/10/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47279</p> <p>Based on surveyor observation, record review, resident and staff interviews, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 2 residents reviewed for a fall resulting in a hospitalization , Resident ID #21 and for 1 of 1 resident reviewed for an injectable anti-psychotic medication, Resident ID #35.</p> <p>Findings are as follows:</p> <p>1. Review of a facility reported incident submitted to the Rhode Island Department of Health on 9/20/2024 revealed that Resident ID #21 fell in his/her room and was transferred to the hospital via 911.</p> <p>Record review revealed Resident ID #21 was admitted to the facility in June of 2024 with diagnoses including, but not limited to, mantle cell lymphoma (cancer) and anxiety disorder.</p> <p>Record review revealed the following progress notes:</p> <p>- 9/18/2024: The resident was found on the floor of his/her room and was sent to the emergency room .</p> <p>- 9/23/2024: The resident was readmitted to the facility with a left hip fracture with recommendations for toe touch weight bearing status (for balancing purposes only; no significant weight should be placed on affected extremity).</p> <p>Review of a hospital document titled, Continuity of Care Document dated 9/23/2024 revealed that the orthopedic surgeon indicated that the resident was not a surgical candidate for repair of his/her left hip fracture and recommended that s/he should continue toe touch weight bearing to his/her left lower extremity.</p> <p>Review of a physical therapy document dated 9/24/2024 revealed that the resident's weight bearing status to his/her left lower extremity is toe touch.</p> <p>Record review failed to reveal evidence of a physician's order for toe touch weight bearing status for Resident ID #21's left lower extremity.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 10/9/2024 at 10:26 AM with Nursing Assistant (NA), Staff A, she revealed that the resident ambulates independently.</p> <p>During a surveyor interview on 10/9/2024 at 12:17 PM with the resident, s/he did not recall falling on 9/18/2024 and was unable to provide any insight regarding the incident or his/her current weight bearing status.</p> <p>During a surveyor interview on 10/9/2024 at 3:05 PM with Licensed Practical Nurse (LPN), Staff B, she revealed that the resident does not have any weight bearing status restrictions.</p> <p>During a surveyor interview on 10/9/2024 at 4:09 PM with the Director of Nursing Services (DNS), she revealed that she was unaware of the resident's toe touch weight bearing status and was unaware that the resident was ambulating independently. Additionally, she revealed that she would expect the recommendation to have been followed.</p> <p>During a surveyor interview on 10/10/2024 at 11:40 AM with the Nurse Practitioner (NP), Staff C, she revealed that she was unaware of the hospital's recommendation for toe touch weight bearing status for Resident ID #21's left lower extremity and would have ordered the resident to be toe touch weight bearing, had she been made aware.</p> <p>Additional record review revealed an order dated 10/9/2024 for the resident to be toe touch weight bearing for his/her left lower extremity, after this concern was brought to the facility's attention by the surveyor.</p> <p>2. Review of a facility policy titled, Medication Administration dated 10/11/2017 states in part, .If a resident refuses medication .a second attempt would be made to administer .If a resident refused the medication . Consistent refusals require notification to the attending physician and the nurse management .</p> <p>Record review revealed Resident ID #35 was admitted to the facility in October of 2014 with diagnoses including, but not limited to, schizoaffective disorder (a chronic mental illness that causes changes in thoughts, mood, and behaviors) and dementia.</p> <p>Record review revealed a physician's order dated 1/9/2024 for Invega Sustenna (an antipsychotic medication) 234 milligrams per 1.5 milliliters, with instructions to inject 1 dose every 28 days, related to his/her schizoaffective disorder.</p> <p>Record review of the August and September 2024 Medication Administration Records revealed that the resident's Invega injection was documented by LPN, Staff D as refused on the following dates:</p> <p>- 8/20/2024</p> <p>- 9/17/2024</p> <p>Review of a progress note dated 8/20/2024 authored by Staff D revealed that the resident refused his/her Invega injection three times but would take the injection the following day.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46338</p> <p>Based on record review, resident and staff interviews, it has been determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed relative to a scheduled orthopedic appointment, Resident ID #55.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in July of 2023 with diagnoses including, but not limited to, atherosclerosis (a common condition that occurs when plaque builds up in the walls of arteries, narrowing or blocking them) of bilateral legs and dementia.</p> <p>Record review of the resident's care plan dated 7/13/2023 revealed that s/he has chronic bilateral knee pain related to atherosclerosis.</p> <p>Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 8 out of 15, indicating a moderately impaired cognition.</p> <p>Record review of a physician's order dated 11/22/2023 revealed an active order for an orthopedic consult.</p> <p>Record review of the nursing progress notes revealed the following:</p> <ul style="list-style-type: none"> <li>- 11/15/2023 - the resident was found in the bathroom complaining of left leg pain and was assisted back to bed. Additionally, the note indicated that the left leg appeared swollen and warm to touch. S/he had difficulty bearing weight and s/he was unable to lift his/her foot more than 3 to 6 inches. Furthermore, the note revealed a plan to contact the provider in the morning.</li> <li>- 11/22/2023 - the note revealed the resident is to have an orthopedic consult relative to the left knee effusion. Further, the progress note indicated that the appointment slip was filled out.</li> <li>- 11/29/2023 - the note revealed that the resident had a swollen left knee and the orthopedic consult appointment was scheduled for 12/4/2023 at 1:30 PM.</li> <li>- 12/4/2023 - The note revealed that the resident refused to attend the scheduled orthopedic appointment with a plan to reschedule the appointment.</li> </ul> <p>Further record review of the progress notes failed to reveal evidence of a rescheduled appointment.</p> <p>Record review of the progress notes revealed the resident continued to complain of left leg pain following the missed orthopedic consult appointment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 10/7/2024 at approximately 10:00 AM with the resident, s/he revealed that his/her left leg is swollen and painful. Further, s/he revealed that the pain causes him/her to not be able to sleep.</p> <p>During a surveyor interview on 10/9/2024 at 12:52 PM with the Licensed Practical Nurse (LPN), Staff E, she acknowledged that the resident complains of left knee pain and indicated his/her pain regimen is not effective.</p> <p>During a surveyor interview on 10/10/2024 at 10:12 AM with the Director of Nursing Services (DNS), she indicated that she was told that the resident refused to go the orthopedic appointment in December of 2023. During the interview, the DNS received a telephone call that the appointment has been rescheduled for 10/30/2024 at 10:45 AM, after it was brought to the facility's attention by the surveyor.</p> <p>During a surveyor interview on 10/10/2024 at 12:36 PM with Nurse Practitioner, Staff C, she revealed that she ordered the orthopedic consult relative to the resident's increased left knee pain in November of 2023. Additionally, she stated that she was aware of the resident's refusal to attend the appointment on 12/4/2024 but, staff had never communicated to her that the resident was still having left leg pain.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47279</p> <p>Based on record review, resident and staff interviews, it has been determined that the facility failed to ensure that each resident receives adequate supervision to prevent accidents for 1 of 1 resident reviewed who requires frequent safety checks, Resident ID #21.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 9/20/2024 revealed that the resident fell in his/her room and was transferred to the hospital via 911.</p> <p>Review of an undated facility policy titled, Falls Prevention Program states in part, .It is the policy of this facility .to establish a care plan that identifies the risk factors exhibited by the resident and which directs staff re [regarding]: measures to be taken to mitigate or eliminate those risk factors .</p> <p>Record review revealed the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, mantle cell lymphoma (cancer) and anxiety disorder.</p> <p>Record review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 8 out of 15, indicating moderately impaired cognition.</p> <p>Record review revealed the following progress notes:</p> <ul style="list-style-type: none"> <li>- 9/18/2024: The resident was found on the floor of his/her room and was sent to the emergency room .</li> <li>- 9/23/2024: The resident was readmitted to the facility with a left hip fracture.</li> </ul> <p>Review of the resident's care plan revealed that s/he is at risk for falls related to weakness and pain, with an intervention for frequent safety checks because s/he is impulsive.</p> <p>Review of the Kardex (a tool used by the direct care staff to provide pertinent information to guide resident care) as of 10/9/2024 revealed that the resident requires frequent safety checks.</p> <p>During a surveyor interview on 10/9/2024 at 10:31 AM with Nursing Assistant, Staff A, she revealed that residents that are on frequent safety checks should be checked every 15 minutes and staff should document them. She further revealed that Resident ID #21 is not on frequent safety checks.</p> <p>During a surveyor interview on 10/9/2024 at 10:46 AM with Licensed Practical Nurse, Staff B, she revealed that Resident ID #21 is not on frequent safety checks.</p> <p>During a surveyor interview on 10/9/2024 at 12:17 PM with the resident, s/he was unable to recall falling or going to the hospital on 9/18/2024 and was unable to provide any insight regarding the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 10/9/2024 at 3:27 PM with the Director of Nursing Services, she acknowledged that the resident requires frequent safety checks per his/her care plan and that staff should be checking on the resident at least every 20-30 minutes. Additionally, she was unable to explain why staff were not aware that the resident required frequent safety checks. Furthermore, she revealed that she would not expect staff to be documenting that the safety checks are being completed and was unable to explain how she would ensure frequent safety checks were taking place for the resident if it is not being documented.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46241</p> <p>Based on record review, resident and staff interviews, 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 for withdrawal symptoms, Resident ID #98.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in February of 2024 with a diagnosis including, but not limited to, opioid dependence.</p> <p>Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition.</p> <p>Review of a document titled, PHYSICIAN'S ORDER dated 10/3/2024, revealed an order for Lorazepam (an anti-anxiety medication), 0.5 milligrams (mg), by mouth, two times a day for 7 days.</p> <p>Review of the October 2024 Medication Administration Record (MAR) revealed the lorazepam was not administered and to See Progress Notes on 10/4/2024 at night and on 10/5/2024 in the morning.</p> <p>Review of the progress notes dated 10/4/2024 at 10:46 PM and 10/5/2024 at 12:42 PM, revealed the Lorazepam was not administered to the resident, as ordered, due to the medication not being delivered to the facility by the pharmacy.</p> <p>Additional review of the October 2024 MAR revealed the resident received his/her first dose of Lorazepam on the morning of 10/6/2024, indicating s/he missed 5 doses of the medication.</p> <p>During a surveyor interview on 10/8/2024 at 11:35 AM, with Licensed Practical Nurse, Staff D, she revealed that she was the nurse who entered the order for Lorazepam on 10/3/2024 to start on 10/4/2024. She further revealed that the medication is available in the pyxis machine (an automated medication dispensing system).</p> <p>During a surveyor interview on 10/8/2024 at 12:07 PM, with the Director of Nursing Services, she revealed that most nurses in the facility have access to the pyxis and acknowledged that Lorazepam is available in the pyxis. She further revealed that she would have expected the resident to have received the Lorazepam right away and indicated that she would expect staff to notify her or the provider that the resident's Lorazepam was not delivered by the pharmacy or administered to the resident.</p> <p>During surveyor interviews on 10/8/2024 at 1:03 PM and 1:17 PM, with Nurse Practitioner, Staff F, she revealed that she would have expected the resident's Lorazepam order to be started on the day it was ordered. Additionally she revealed that it was not administered to the resident until 10/6/2024, 4 days after it was ordered. She further revealed that she would expect to be notified if the medication was unavailable.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46539</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to Enhanced Barrier Precautions (EBP; which requires the donning of (putting on) a gown and gloves during high-contact resident care activities), for 5 of 6 residents reviewed, Resident ID #s 4, 37, 82, 86, and 304 and for 2 of 2 residents reviewed for Covid-19, Resident ID #s 14 and 94.</p> <p>Findings are as follows:</p> <p>1. Review of a facility policy titled, Isolation last revised on 9/19 states in part, .It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions .Enhanced Barrier Precautions .the use of gown and gloves during high contact resident care .Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing . Bathing/showering .transferring .providing hygiene .changing linens .changing briefs or assisting with toileting .device care or use: central line, urinary catheter, feeding tube, tracheotomy/ventilator .wound care: any skin opening requiring a dressing .</p> <p>a. Record review revealed Resident ID #4 was readmitted to the facility in September of 2023 with a diagnosis that includes, but is not limited to, spina bifida (a birth defect in a baby that occurs when the spine and the spinal cord do not develop completely).</p> <p>Additional record review revealed that the resident has wounds that require daily wound care.</p> <p>During a surveyor observation on 10/8/2024 at 10:47 AM, revealed Nursing Assistant, Staff I, was transferring the resident without wearing a gown.</p> <p>During a surveyor interview immediately following the above observation, Staff I acknowledged that the resident was on EBP. Additionally, she acknowledged that she did not wear a gown during the resident's transfer.</p> <p>During a surveyor interview on 10/8/2024 at 10:52 AM with Registered Nurse (RN), Staff J, she revealed that she would expect staff to wear a gown when transferring a resident who is on EBP.</p> <p>Review of the resident's care plan revealed a focus area initiated on 10/8/2024, after this concern was brought to the facility's attention by the surveyor, which revealed that the resident requires EBP related to wounds, with an intervention to include, but is not limited to, gloves and a gown must be worn during high-contact care activities.</p> <p>b. Record review revealed that Resident ID #37 was readmitted to the facility in October of 2024 with diagnoses including, but not limited to, difficulty in walking and the presence of a left artificial hip joint.</p> <p>Additional record review revealed that the resident has wounds that require daily wound care.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During surveyor observations on 10/7/2024 at 8:49 AM, 10/8/2024 at 10:52 AM and 11:03 AM, failed to reveal evidence of EBP signage, or a supply of personal protective equipment (PPE) located at the resident's door.</p> <p>Review of the resident's care plan revealed a focus area initiated on 8/19/2024 with interventions to include, but are not limited to, that the resident requires EBP related to wounds.</p> <p>During a surveyor interview with RN, Staff K, he acknowledged that the resident was not on EBP and indicated s/he should have been on EBP related to his/her wound.</p> <p>c. Record review revealed that Resident ID #82 was admitted to the facility in May of 2022 with diagnoses including, but not limited to, type II diabetes and difficulty walking.</p> <p>Additional record review revealed the resident has wounds that require daily wound care.</p> <p>During surveyor observations on 10/7/2024 at 11:10 AM, 10/8/2024 at 9:30 AM and 11:26 AM, failed to reveal evidence of EBP signage, or a supply of PPE located at the resident's door.</p> <p>During a surveyor interview on 10/8/2024 at 11:29 AM with Licensed Practical Nurse (LPN), Staff D, she acknowledged that the resident was not on EBP and indicated s/he should have been on EBP related to his/her wounds.</p> <p>Review of the resident's care plan revealed a focus area initiated on 10/8/2024, after this concern was brought to the facility's attention by the surveyor, which revealed that the resident requires EBP related to wounds. The interventions include, but are not limited to, gloves and a gown must be worn during high-contact care activities.</p> <p>d. Record review revealed that Resident ID #86 was readmitted to the facility in August of 2024 with a diagnosis including, but is not limited to, adult failure to thrive.</p> <p>Additional record review revealed the resident has a gastrointestinal tube (Peg-Tube; feeding tube, a tube that is inserted through the abdomen and into the stomach, which allows liquid nutrition to be administered directly into the stomach).</p> <p>During surveyor observations on 10/7/2024 at 11:39 AM and 10/8/2024 at 8:17 AM, failed to reveal evidence of EBP signage, or a supply of PPE located at the resident's door.</p> <p>During a surveyor interview on 10/8/2024 at 11:00 AM with RN, Staff K, he acknowledged that the resident was not on EBP and indicated s/he should have been on EBP related to having a Peg Tube.</p> <p>Review of the resident's care plan revealed an intervention initiated on 10/8/2024, after this concern was brought to the facility's attention by the surveyor, which revealed the resident requires EBP related to having a Peg Tube.</p> <p>e. Record review revealed that Resident ID #304 was admitted to the facility in September of 2024 with a diagnosis including, but is not limited to, dementia.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Additional record review revealed the resident has an indwelling foley catheter (a flexible tube inserted into the bladder to drain urine).</p> <p>During surveyor observations on 10/7/2024 at 11:40 AM and 10/8/2024 at 8:16 AM, revealed the resident had an indwelling catheter at his/her bedside. Further observation failed to reveal evidence of EBP signage, or a supply of PPE located at the resident's door.</p> <p>During a surveyor interview on 10/8/2024 at 11:01 AM with RN, Staff K, he acknowledged that the resident was not on EBP and indicated s/he should have been on EBP related to having an indwelling catheter.</p> <p>Review of the resident's care plan revealed a focus area initiated on 10/8/2024, after this concern was brought to the facility's attention by the surveyor, which revealed the resident requires EBP related to having an indwelling catheter. The interventions include, but are not limited to, gloves and a gown must be worn during high-contact care activities.</p> <p>During a surveyor interview with the Infection Preventionist on 10/8/2024 at 11:05 AM, he revealed that he would expect that, when a resident is on EBP, that staff wear a gown when assisting with a transfer. He further revealed that he would expect residents with a Peg tube, indwelling catheter and a wound that requires a dressing to be on EBP precautions.</p> <p>During a surveyor interview with the Director of Nursing Services (DNS) on 10/8/2024 at 11:16 AM, she revealed that she would expect staff to wear a gown to transfer a resident if the resident is on EBP. Additionally, she revealed that she would expect that residents with a Peg tube, indwelling catheter and a wound that requires a dressing to be on EBP precautions.</p> <p>2. Review of facility signage titled DROPLET CONTACT PRECAUTIONS EVERYONE MUST: for Covid-19, providers and staff must wear a mask at all times, wear gloves, a gown, and a face shield prior to entering a resident's room. Further review of the signage reveals that everyone must clean their hands before entering and after leaving the room.</p> <p>a. Record review revealed that Resident ID #14 was readmitted to the facility in July of 2024 with a diagnosis including, but is not limited to, vascular dementia.</p> <p>Record review revealed that the resident tested positive for Covid-19 on 9/28/2024.</p> <p>During a surveyor observation on 10/7/2024 at 9:18 AM, revealed the resident was on droplet/contact precautions for Covid-19.</p> <p>During a surveyor observation on 10/7/2024 at 12:14 PM, revealed Certified Medication Technician, Staff L, enter Resident ID #14's room to deliver his/her roommate a lunch tray. Staff L failed to don gloves, a gown, or wear a face shield. Staff L then proceeded to exit the room without cleaning her hands. Staff L then delivered lunch trays to two more rooms for residents who were not on precautions for Covid-19. She then re-entered Resident ID #14's room to deliver him/her a lunch tray. Staff L again failed to don gloves, a gown, or wear a face shield prior to entering the resident's room. She then exited the room and again failed to clean her hands.</p> <p>(continued on next page)</p>		

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  10/10/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview immediately following the above observations with Staff L, she revealed that she thought that the precautions were only used during direct care and were not required when delivering a meal tray. Additionally, she acknowledged that the signage states to put on gloves, gown, and face shield prior to entering the resident's room and to clean hands before entering and after exiting the room.</p> <p>During a surveyor interview on 10/8/2024 at 11:03 AM with RN, Staff K, he revealed that when a resident is positive for Covid-19 staff should don a, gown, gloves, and wear an N95 mask and a face shield.</p> <p>b. Record review revealed that Resident ID #94 was readmitted to the facility in September of 2024 with a diagnosis including, but is not limited to, schizophrenia.</p> <p>Record review revealed that the resident tested positive for Covid-19 on 9/28/2024.</p> <p>During a surveyor observation on 10/7/2024 at 8:56 AM, revealed that the resident was on droplet/contact precautions for Covid-19.</p> <p>During a surveyor observation on 10/7/2024 at 8:56 AM, revealed two laundry staff members, Staff M and N enter Resident ID #94's room with clean laundry for both residents who reside in the room. Both Staff M and N failed to don a gown, gloves, or wear a face shield prior to entering the room. Additionally, they both failed to perform hand hygiene prior to entering or after exiting the room.</p> <p>During an attempted surveyor interview immediately following the above observation with Staff M, she indicated that she and Staff N did not speak English and were unable to read the signage, stating No habla [NAME].</p> <p>During a surveyor interview on 10/8/2024 at 11:03 AM with RN, Staff K, he revealed that when a resident is positive for Covid-19 staff should don a gown, gloves, and wear an N95 mask and a face shield.</p> <p>During a surveyor interview with the Infection Preventionist on 10/8/2024 at 11:05 AM, he revealed that he would expect staff to don a gown, gloves, and wear a face shield prior to room entry. Additionally, he revealed that he would expect staff to clean their hands after leaving a resident's room who is on precautions. Furthermore, he revealed that the signage posted is for both residents that resident in the room, regardless of their Covid-19 status. If one resident is positive the staff need to wear a gown, gloves, N95 mask and face shield for both residents, due to exposure.</p> <p>During a surveyor interview with the DNS on 10/8/2024 at 11:16 AM, she revealed that she would expect staff to have donned a gown, gloves, and wear a face shield prior to room entry for both Resident ID #s 14 and 94's rooms. Additionally, she revealed that staff should perform hand hygiene as stated on the signage posted near the resident's doors.</p>		