STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Rehabilitation & Health Care Center	123 South Street Plymouth, MA 02360

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure nursing staff provided care and services in accordance with professional standards of practice related to medication administration. When on 2/02/23, Resident #1, who did not have Physician ordered medications scheduled to be administered at 9:00 P.M., was administered another residents (Resident #3's) evening medications in error by Nurse #3, who did not follow Facility policy or adhere to nursing standards of practice when dispensing and administering medications to residents. Approximately one hour later, Resident #1 became extremely pale, difficult to arouse, his/her blood pressure and heart rate dropped, he/she was transferred to the Hospital Emergency Department (ED) for evaluation, and was admitted to the Intensive Care Unit (ICU) for treatment. Findings include: Standard Reference: Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a registered nurse and practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered and practical nurse incorporated into the plan of care, and implement prescribed medical regimens. The rules and regulations 9.03 defined standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Review of the Facility Policy titled, Medication Administration - Oral, dated June 2015, indicated the following: -Verify medication order on the medication administration record (MAR), check against physician order -Identify the resident -Avoid distractions and interruptions when preparing and administering medications -Only prepare one resident medication at a time (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Actual harm Residents Affected - Few	-Compare the medication label to the resident's MAR -Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route -Document medications administration Resident #1 was admitted to the Facility in June 2009, diagnoses included spastic quadriplegic cerebral palsy, intellectual disabilities, microcephaly, gastrostomy status and epilepsy. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated , 1/06/22, indicated he/she was severely cognitively impaired and required total dependence of two staff members for activities of daily living. Review of Resident #1's Decree of Guardianship of Mentally Retarded Record, dated 7/20/1987, indicated he/she was incapable of caring for him/herself by reason of mental retardation. Review of Facility Medication Incident Report, dated 2/02/23 at 11:00 P.M., indicated Nurse #3 administered Resident #1 the wrong medications, that the medications were ordered for a resident with the same last name. Review of the Facility's Internal Investigation Report, dated 2/03/23, indicated that during the 3:00 P.M. to 11:00 P.M. shift (on 2/02/23), Resident #1 was given medications that were ordered for another resident (Resident #3) with a similar last name. The Report indicated that Resident #1 experienced a noted drop in blood pressure and was transferred to the Hospital (ED) for monitoring of hypotension (low blood pressure). The Report indicated that Resident #1 received the following medications in error: -Escitalopram (antidepressant) 20 milligrams (mg) -Trazadone (antidepressant) 50 mg -Clonidine (antihypertensive) 0.2 mg -Gabapentin (anticonvulsant) 800 mg -Suboxone (opioid narcotic, used to treat narcotic dependence) 8-2 mg -Clonazepam (benzodiazepine sedative) 2 mg -Melatonin (used to treat insomnia) 5 mg During an interview on 2/24/23 at 9:07 A.M., with Nurse #3, (which included a review of her written witness statement, dated 2/03/23, regarding Resident #1's medication error), Nurse #3 said that on 2/02/23 at 9:00 P.M., she was preparing Resident #3's medications at the medication cart, entered his/her room and found him/her asleep. Nurse #3 said Resident #3 did not wake up when she called his/her name and said rather than wake him/her up and possibly upset him/her, she wrote his/her last name on the medication cup and placed it in the top drawer of the medication cart. (continued on next page)

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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 0658 Level of Harm - Actual harm Residents Affected - Few	Nurse #3 said she continued on with her medication pass. Nurse #3 said she prepared Resident #1's roommate's evening medications and when she brought those medications into the room, she also brought in the medication cup (that contained Resident #3's medications) that was labeled with the same last name as Resident #1 with her. Nurse #3 said that she got distracted, was unfocused, and mistakenly thought that the medications in the cup labeled with the same last name as Resident #1 (but contained Resident #3's medications) were Resident #1's medications and said she administered them to Resident #1 in error. Nurse #3 said that when she left Resident #1's room, Resident #3 was in the doorway to his/her room waiting for his/her medications and said that was when she realized that she had administered Resident #3's medications to Resident #1 in error. Nurse #3 said that Resident #1 did not have any medications scheduled at 9:00 P.M., and that she had already administered Resident #1 his/her medications earlier in the evening. Nurse #3 said she could not explain why she administered medications to Resident #1 when she knew he/she did not have any medications ordered at 9:00 P.M. Nurse #3 said she usually prepares the medications of both residents, who are in the same room, at the same time. Nurse #3 said she labels the medication cups with their last name, and brings both medication cups into the room at the same time to save time on her medication pass. Nurse #3 said she did not look at Resident #1's MAR prior to administering him/her the medications and said she did not follow the Facility's policy regarding medication administration. During an interview on 2/22/23 at 11:58 A.M., the Nursing Supervisor said that Nurse #3 reported to her that she had administered the wrong medications to Resident #1. The Nursing Supervisor, who worked the following shift after the medication error occurred, said she monitored Resident #1's blood pressure and heart rate following the medication error. The Nursing Supervisor said that approximately an hour after the medication error, Resident #1 became extremely pale, was difficult to arouse and said his/her blood pressure and heart rate dropped. The Nursing Supervisor said that she notified the Physician and said Resident #1 was transferred to the Hospital ED for evaluation. Review of Resident #1's Medication Administration Record (MAR), dated for 2/02/23, indicated his/her Physician Orders for evening medications to be administered via his/her jejunostomy (surgical opening in the small intestine from outside the body, allowing placement of a feeding tube) included the following: -Levothyroxine (used to treat an underactive thyroid) 25 micrograms (mcg) tablet, give one tablet via jejunostomy tube (J-tube) at 6:00 P.M. -Docusate Sodium (used to treat constipation) capsule 100 mg, give one capsule via J-tube at 6:00 P.M. -Diazepam (benzodiazepine sedative) tablet 5 mg, give one tablet via J-tube at 6:00 P.M. Review of Resident #3's Medication Administration Record, dated 2/02/23, indicated his/her Physician's Orders for evening medication included the following: -Escitalopram (antidepressant) tablet 20 mg, give one tablet by mouth (PO) daily at 9:00 P.M. (continued on next page)

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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 0658 Level of Harm - Actual harm Residents Affected - Few	-Trazodone (antidepressant) tablet 50 mg, give one tablet PO at bedtime at 9:00 P.M. -Clonidine (antihypertensive) tablet 0.2 mg, give one tablet PO at 9:00 P.M. -Gabapentin (anticonvulsant) tablet 800 mg, give one tablet PO at 9:00 P.M. -Suboxone (opioid narcotic, used to treat opioid addiction) 8-2 mg, give one tablet sublingually (under the tongue) at 9:00 P.M. -Clonazepam (benzodiazepine sedative) tablet 2 mg, give one tablet PO at 9:00 P.M. -Melatonin (used to treat insomnia) tablet 5 mg, give one tablet PO at bedtime at 9:00 P.M. During an interview on 2/22/23 at 1:15 P.M., the Director of Nurses (DON) said Nurse #3 told her that she had pre-poured Resident #3's medications and left them in the top drawer of the medication cart labeled with his/her last name. The DON said that Nurse #3 said she administered Resident #3's medications, that were labeled with the same last name as Resident #1, in error, to Resident #1. The DON said that Nurse #3 did not follow the basic nursing practice of medication administration and said she did not follow the Facility's medication administration policy. Review of Resident #1's Hospital Discharge Summary, dated 2/03/23, indicated that at approximately 11:00 P.M. on 2/02/23, Resident #1 received another resident's medications. The Summary indicated that Resident #1 received Narcan (narcotic, can treat narcotic overdose in an emergency situation) 4 mg by Emergency Medical Services (EMS) en route to the emergency room with no appreciable improvement. The Summary indicated that Resident #1 was lethargic, had a depressed respiratory rate, was bradycardic (low heart rate) and received another dose of Narcan in the emergency room with no appreciable improvement. The Summary indicated that Resident #1 received atropine (used to treat a slow heart rate), intravenous fluids, and low dose neosynephrine (used to treat acute low blood pressure) for profound bradycardia, hypotension (low blood pressure) and first-degree AV Block (atrioventricular heart block) and was admitted to the Intensive Care Unit (ICU) for close monitoring.

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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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37183 Based on records reviewed and interviews for one of three sampled residents (Resident #1), the Facility failed to ensure he/she was free from significant medication errors that adversely impacted his/her health. On 2/02/23, Resident #1, who did not have any Physician ordered medications to be administered at 9:00 P.M., was administered Resident #3's 9:00 P.M. medications by Nurse #3 in error. Approximately one hour later, Resident #1 became extremely pale, was difficult to arouse, and his/her blood pressure and heart rate dropped. Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation and required admission to the Intensive Care Unit (ICU) for treatment and monitoring. Findings Include: Review of the Facility Policy titled, Medication Administration - Oral, dated June 2015, indicated the following: -Verify medication order on the medication administration record (MAR), check against physician order -Identify the resident -Avoid distractions and interruptions when preparing and administering medications -Only prepare one resident medication at a time -Compare the medication label to the resident's MAR -Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route -Document medications administration Resident #1 was admitted to the Facility in June 2009, diagnoses included spastic quadriplegic cerebral palsy, intellectual disabilities, microcephaly, gastrostomy status and epilepsy. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated , 1/06/22, indicated he/she was severely cognitively impaired and required total dependence of two staff members for activities of daily living. Review of Resident #1's Decree of Guardianship of Mentally Retarded Record, dated 7/20/1987, indicated he/she was incapable of caring for him/herself by reason of mental retardation. Review of Resident #1's Facility Medication Incident Report, dated 2/02/23 at 11:00 P.M., indicated Nurse #3 administered the wrong medications from a resident with the same last name. (continued on next page)

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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 - Actual harm Residents Affected - Few	Review of the Facility's Internal Investigation Report, dated 2/03/23, indicated that on 2/02/23 on the 3:00 P. M. through 11:00 P.M. shift, Resident #1 was given the medications of another resident with a similar last name. The Report indicated that Resident #1 experienced a noted drop in blood pressure and was transferred to the Hospital for monitoring of hypotension (low blood pressure). The Report indicated that Resident #1 received the following medications in error: -Escitalopram (antidepressant) 20 milligrams (mg) -Trazadone (antidepressant) 50 mg -Clonidine (antihypertensive) 0.2 mg -Gabapentin (anticonvulsant) 800 mg -Suboxone (opioid narcotic, used to treat narcotic dependence) 8-2 mg -Clonazepam (benzodiazepine sedative) 2 mg -Melatonin (used to treat insomnia) tablet 5 mg Review of Resident #1's Hospital Discharge Summary, dated 2/03/23, indicated that at approximately 11:00 P.M. on 2/02/23, Resident #1 received another resident's medications. The Summary indicated that Resident #1 received Narcan (narcotic, can treat narcotic overdose in an emergency situation) 4 mg by Emergency Medical Services (EMS) en route to the emergency room with no appreciable improvement. The Summary indicated that Resident #1 was lethargic, had a depressed respiratory rate, was bradycardic (low heart rate) and received another dose of Narcan in the emergency room with no appreciable improvement. The Summary indicated that Resident #1 received atropine (used to treat a slow heart rate), intravenous fluids, and low dose neosynephrine (used to treat acute low blood pressure) for profound bradycardia, hypotension (low blood pressure) and first-degree AV Block (atrioventricular heart block) and was admitted to the Intensive Care Unit (ICU) for close monitoring. During an interview on 2/24/23 at 9:07 A.M., with Nurse #3 and review of Nurse #3's Written Witness Statement, dated 2/03/23, regarding the medication error on 2/02/23, indicated the following: Nurse #3 said that at 9:00 P.M., she was preparing Resident #3's medications at the medication cart, entered his/her room and found him/her asleep. Nurse #3 said that Resident #3 did not wake up when she called his/her name and said rather than wake him/her up and possibly upset him/her, she wrote his/her last name on the medication cup and placed it in the top drawer of the medication cart. Nurse #3 said she continued on with her medication pass. Nurse #3 said she prepared Resident #1's roommate's medications and when she brought in the roommates medications into the room, she also brought in the medication cup (containing Resident #3's medications) that was labeled with the same last name as Resident #1 with her. Nurse #3 said that she got distracted, was unfocused, and mistakenly thought that the medications in the cup (which she had dispensed to administered to Resident #3, who had the same last name as Resident #1) that they were Resident #1's medications and said she administered them to Resident #1 in error. (continued on next page)

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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 - Actual harm Residents Affected - Few	Nurse #3 said that when she left Resident #1's room, Resident #3 was standing in the doorway to his/her room waiting for his/her medications and said that was when she realized that she had administered Resident #3's medications to Resident #1 in error. Nurse #3 said that Resident #1 did not have any medications scheduled to be administered at 9:00 P.M., that his/her medications are administered earlier in the evening. Nurse #3 said she could not explain why she administered medications to Resident #1 when she knew he/she did not have any medications ordered at 9:00 P.M. Nurse #3 said she usually prepares the medications of both residents, who are in the same room, at the same time. Nurse #3 said she labels the medication cups with the residents last name, and brings both medication cups into the room at the same time to save time on her medication pass. Nurse #3 said she did not look at Resident #1's MAR prior to administering him/her the medications and said she did not follow the Facility's medication administration policy. During an interview on 2/22/23 at 11:58 A.M., the Nursing Supervisor said that on 2/02/23, Nurse #3 reported to her that she had administered the wrong medications to Resident #1. The Nursing Supervisor, who worked the following shift after the medication error occurred, said she monitored Resident #1's blood pressure and heart rate following the medication error. The Nursing Supervisor said that approximately an hour after the medication error, Resident #1 became extremely pale, was difficult to arouse and said his/her blood pressure and heart rate dropped. The Nursing Supervisor said that she notified the Physician and said Resident #1 was transferred to the Hospital ED for evaluation. Review of Resident #1's Medication Administration Record (MAR), dated for 2/02/23, indicated his/her Physician Orders for evening medications to be administered via his/her jejunostomy (surgical opening in the small intestine from outside the body, allowing placement of a feeding tube) included the following: -Levothyroxine (used to treat an underactive thyroid) 25 micrograms (mcg) tablet, give one tablet via jejunostomy tube (J-tube) at 6:00 P.M. -Docusate Sodium (used to treat constipation) capsule 100 mg, give one capsule via J-tube at 6:00 P.M. -Diazepam (benzodiazepine sedative) tablet 5 mg, give one tablet via J-tube at 6:00 P.M. Review of Resident #3's Medication Administration Record, dated 2/02/23, indicated his/her Physician's Orders for evening medication included the following: -Escitalopram (antidepressant) tablet 20 mg, give one tablet by mouth (PO) daily at 9:00 P.M. -Trazodone (antidepressant) tablet 50 mg, give one tablet PO at bedtime at 9:00 P.M. -Clonidine (antihypertensive) tablet 0.2 mg, give one tablet PO at 9:00 P.M. -Gabapentin (anticonvulsant) tablet 800 mg, give one tablet PO at 9:00 P.M. -Suboxone (opioid, narcotic used to treat narcotic dependence) 8-2 mg, give one tablet sublingually (under the tongue) at 9:00 P.M. (continued on next page)

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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 - Actual harm Residents Affected - Few	-Clonazepam (benzodiazepine sedative) tablet 2 mg, give one tablet PO at 9:00 P.M. -Melatonin (used to treat insomnia) tablet 5 mg, give one tablet PO at bedtime at 9:00 P.M. During an interview on 2/22/23 at 1:15 P.M., the Director of Nurses (DON) said Nurse #3 told her that she had pre-poured Resident #3's medications and left them in the top drawer of the medication cart labeled with his/her last name. The DON said that Nurse #3 said she administered Resident #3's medications, that were labeled with the same last name as Resident #1, in error to Resident #1. The DON said that Nurse #3 did not follow the basic nursing practice of medication administration and said she did not follow the Facility's medication administration policy.