STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075316	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glastonbury Center for Health & Rehabilitation	1175 Hebron Ave Glastonbury, CT 06033

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of four (4) sampled residents (Resident #3) who were reviewed for medication administration, the facility failed to ensure Resident #3did not receive medications that were prescribed for another resident. The findings include: Resident #3's diagnoses included hypertension, depression, anxiety, and history of acute renal failure. The admission Minimum Data Set assessment dated [DATE] identified Resident #3 was alert and oriented to person, place, time and situation. A physician's order dated 3/3/25 directed to administer the following medications at 9:00 AM: Acetaminophen 500 milligrams (mg), Allopurinol 100 mg, Atorvastatin Calcium 20 mg, Buspirone HCl 10 mg, Duloxetine HCl 10 mg, Ferrous Sulfate 325 mg, Folic Acid 1 mg, Losartan 25 mg, Magnesium Oxide 400 mg, Multivitamin one (1) tablet, and Oxybutynin ER 5mg. The nurse's noted dated 3/21/25 at 2:12 PM identified the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, was called into Resident #3's room by the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, due to a medication error. The note indicated upon assessment no adverse reactions were noted, Resident #3 was awake, alert, and oriented times four (4), was made aware of the error and verbalized understanding. The note identified the Advanced Practice Registered Nurse (APRN) was notified and directed to monitor Resident #3's vital signs every four (4) hours for three (3) days, to schedule lab work, and to monitor Resident #1 for bleeding or bruising each shift. The Nurse Practitioner's order dated 3/21/25 directed to hold the morning medications on 3/21/25. Review of the nurse's notes from 3/21/25 through 3/23/25 identified Resident #3 had no ill effects from receiving another resident's medication. The physician's progress notes dated 3/24/25 and 3/27/25 identified the APRN reviewed the lab work, and no further orders were given. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Reported Incident form dated 3/21/25 identified Resident #3 received another resident's 9:00 AM medications on 3/21/25. The investigation identified the following medications were ordered for Resident #4 at 9:00 AM and administered to Resident #3: Vitamin B12 2000 mcg, Proscar 0.5 mg and Flomax 0.4 mg (medications to treat enlarged prostrate), Ferrous Gluconate 324 mg, Folic Acid 1 mg, Losartan 50 mg and Metoprolol 25 mg, (medications to treat hypertension), Protonix 40 mg (a medication to reduce the amount of acid in the stomach, and (blood thinner medications) Clopidogrel 75 mg and Eliquis 5 mg. Interview with the 7AM-3PM Nursing Supervisor, RN #1, on 5/14/25 at 9:50 AM identified on 3/21/25 at approximately 11:00 AM, the 7AM-3PM charge nurse, LPN #1, reported to her immediately after he had given another resident's, Resident #4, medications to Resident #3 in error. RN #1 identified LPN #1 did not follow the standards of practice or company policy when administering medications. Interview with the 7AM-3PM charge nurse, LPN #1, on 5/14/25 at 10:00 AM identified on 3/21/25 he had prepared Resident #4's medications to administer. Resident #4 was in the bathroom and it was taking a long time, so he proceeded to prepare the medications for Resident #3. LPN #1 explained while at the medication cart, a physical therapist, who was working with Resident #3, called for help because the therapist was having difficulty getting Resident #3 back to bed safely. LPN #1 stated he ran into the room, with both medication cups filled with Resident #3 and #4's medications, placed the cups down on the bedside table and proceeded to assist getting Resident #3 back into bed. LPN #1 identified once back in bed, Resident #3 asked for his/her medications and he administered the wrong pills that were at the bedside. LPN #1 identified he did not look at the medications before handing Resident #3 the pills and immediately realized the mistake and had RN #1 come to the room. LPN #1 indicated he should have locked Resident #4's medications up in the medication cart before proceeding to prepare Resident #3's medications and stated that he did not follow company protocol for the administration of medication. Interview with the Director of Nursing (DON) on 5/14/25 at 2:00 PM identified the APRN directed not to administer Resident #3 the 9:00 AM medications on 3/21/25. The DON identified LPN #1 did not follow company policy for the administration of medication. Review of the Medication Administration policy directed that the six (6) rights of a medication pass which included right resident, right drug, right dose, right dosage form, right route and right time would be followed.