STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075326	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Center for Health & Rehabilitation	205 Chestnut Hill Road Stafford Springs, CT 06076

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident # 1) reviewed for medication administration, the facility failed to prevent a medication error when a licensed nurse administered medications to an incorrect resident and failed to notify a Registered Nurse and the provider of the medication error once discovered. The findings include: 1. Resident #2 was admitted to the facility with diagnoses that included fracture of the left tibial spine, heart failure, hypertension and history of breast cancer. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 14) and was independent with eating with set up help. The care plan dated 4/5/25 identified Resident #2 had the potential for untoward effects due to anticoagulant therapy. Interventions included medication considerations and report side effects of anticoagulant therapy to the nurse. Review of Physician orders identified Resident #2 was prescribed the following medications: a. Omeprazole 20 mg one tablet by mouth for GERD at 8:00 AM b. Atorvastatin 40 mg once a day by mouth for hyperlipidemia at 9:00 AM c. Apixaban .5 mg two times a day by mouth for knee arthroplasty at 9:00 AM d. Plaquenil 200 mg once a day by mouth for arthritis at 9:00 AM e. Anastrozole 1 mg once a day by mouth for breast cancer at 9:00 AM f. Metoprolol 50 mg once a day by mouth for hypertension at 9:00 AM g. Furosemide 40 mg once a day for congestive heart failure at 9:00 AM h. Sacubitril Valsartan 24-26 mg once a day by mouth for hypertension at 9:00 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #1 was admitted to the facility with diagnoses that included fracture of the right femur, atrial fibrillation, epilepsy, hypertension and heart failure. Resident #1's allergies were oxycodone and the pneumococcal vaccine. The care plan dated 4/18/25 identified Resident #1 had the potential for altered cardiac status related to hypertension, congestive heart failure, atrial fibrillation, hyperlipidemia, hypotension and had a pacemaker. Interventions included vital signs per protocol and as needed. A physician's order dated 4/19/25 directed Metoprolol 25 mg tablet half tablet once a day for hypertension. The admission MDS assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was independent with eating with set up help. A physician's order dated 4/24/25 directed Midodrine 5 mg two times a day for hypotension. A nursing note by RN #1 dated 4/30/25 at 10:30 AM identified Resident #1 received the following wrong medications: Omeprazole 20 mg, Atorvastatin 40 mg, Apixaban .5 mg, Plaquenil 200 mg, Anastrozole 1 mg, Metoprolol 50 mg, Furosemide 40 mg and Sacubitril Valsartan 24-26 mg. Resident #1's blood pressure dropped to 77/46 and Resident #1 was given fluids, Midodrine 5 mg and placed in Trendelenburg position. Resident #1's blood pressure was checked every 15 minutes, and the systolic blood pressure remained in the 80's. Resident #1 denied dizziness, lightheadedness, nausea, vomiting or headache. Resident #1 was able to take fluids without difficulty and remained alert and orientated. The APRN and MD were updated and ordered Resident #1 be transferred to the emergency department (ED) for further evaluation. The ED note dated 4/30/25 identified Resident #1 received a 1-liter bolus of normal saline at 10:57 AM. Poison control was contacted and were not concerned of potential drug interactions. They did not anticipate significant ill effects from the medications other than metoprolol, as the patient was likely prone to hypotension since he/she was prescribed Midodrine. A nursing note dated 4/30/25 at 8:10 PM identified Resident #1 returned to the facility. Resident #1 received 1500 ml of fluid and was stable at the ED. The accident and incident (A & I) form dated 4/30/25 at 8:45 AM identified Resident #1 was administered Resident #2's medications (his/her roommate) in error. Resident #1's blood pressure was monitored every fifteen minutes until transfer to the emergency department (ED). Vital sign monitoring was completed for all other residents on the floor. The medication administration record (MAR) identified on 4/30/25 at 9:00 AM midodrine 5mg was administered. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 5/14/25 at 11:23 AM identified she prepared medications for Resident #2 on 4/30/25 at the doorway of Resident #1's and Resident #2's room then entered the room and approached Resident #1. She asked Resident #1 if she was Mary and Resident #1 answered yes. She identified she did not check Resident #1's name identification bracelet but checked the picture in the medical record, which she thought looked like Resident #2. She identified she gave Resident #1 the cup of medications and did not tell Resident #1 what the medications were. Resident #1 then asked LPN #1 where her Keppra medication was. LPN #1 went back to the medication cart and found no order for Keppra then realized she administered the medications to the wrong resident. She turned to Resident #1 and he/she already swallowed the medications. She identified she could not find the supervisor to report the medication error so she told LPN #2 that Resident #1 received Resident #2's medications. She then took Resident #1's vital signs, gave Resident #1 fluids and midodrine, placed Resident #1 back into bed into Trendelenburg position. She identified that she continued with her medication pass, including given Resident #2 his/her prescribed medications. Resident #1 did not receive any other medications other than Midodrine. She identified she failed to ensure she had the right resident when administering medications. Interview with RN #1 on 5/14/25 at 12:42 PM identified that around 9:00 AM on 4/30/25 she was notified by LPN #2 that LPN #1 gave Resident #1 50 mg of Metoprolol, not his/her prescribed amount of 12.5 mg. RN #1 identified she assessed Resident #1, his/her systolic blood pressure was 77 (normal systolic blood pressure is 120), and she notified the APRN. Resident #1 was given water, assisted into bed in Trendelenburg position, and blood pressure was monitored every fifteen minutes. She identified she reported the medication error to the DNS at morning report. The DNS asked her to verify the error and RN #1 then discovered Resident #1 received all of Resident #2's morning medications, not just the Metoprolol. The APRN was updated and ordered Resident #1 be sent to the ED. RN #1 identified LPN #1 continued the morning medication pass, as the error was not identified as significant when she was first notified. She identified all the residents LPN #1 administered medications to had their vital signs assessed. RN #1 identified residents should be verified by their name band, picture and date of birth for medication administration and if a resident does not have a name band on, another staff member should verify the resident. Interview with the DNS on 5/14/25 at 1:00 PM identified on 4/30/25 when LPN #1 identified the medication error, she could not find the supervisor so told LPN #2 that Resident #1 received the wrong blood pressure medication and was concerned about Resident #1's blood pressure. The DNS identified LPN #1 did not tell LPN #2 that Resident #1 received all of Resident #2's medications. LPN #2 reported the medication error to RN #1 who then reported the medication error to her (the DNS). It was then discovered that LPN #1 administered all of Resident #2's medications to Resident #1. LPN #1 had competed the medication pass at that time, and the DNS had her leave the building. She identified if she knew LPN #1 administered all of Resident #2's medications to Resident #1, they would have stopped LPN #1 immediately in her medication pass. She identified all other residents LPN #1 administered medications to had their vital signs assessed and were all stable. The DNS identified Resident #1 had a name identification band on for LPN #1 to verify the resident appropriately. She further identified two verifications should be used to identify a resident before medications are administered. Subsequent to the event, medication administration education for all staff was initiated on 4/30/25, LPN #1 was provided medication administration education from her agency and would not be returning to the facility, QAPI improvement plan was initiated on 4/30/25 with a target completion date of 6/1/25 and medication administration audits were initiated on 5/1/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to conduct education or audits related to the failure of notification of a Registered Nurse for a timely assessemnt and timely notification of a provider. Review of the Medication Error Policy directed that a medication error is a discrepancy between what the healthcare provider ordered and what the resident received. Significant med error means one that causes an adverse effect to the resident (discomfort, jeopardized his/her health safety). Review of the Medication Pass policy directed to identify each resident prior to administration (picture, ID bracelet, etc.), know diagnosis and indication for every medication, do not pre-pour medication, administer them as they are prepared. Always observe the resident until they have swallowed all medications that have been administered, do not leave medication in med cup at bedside or tableside. It further directed to remember the six rights: right resident, drug, dose, dosage form, route and time.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident # 1) reviewed for medication administration, the facility failed to prevent a medication error when a licensed nurse administered medications to an incorrect resident. The findings include: 1. Resident #2 was admitted to the facility with diagnoses that included fracture of the left tibial spine, heart failure, hypertension and history of breast cancer. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 14) and was independent with eating with set up help. The care plan dated 4/5/25 identified Resident #2 had the potential for untoward effects due to anticoagulant therapy. Interventions included medication considerations and report side effects of anticoagulant therapy to the nurse. Review of Physician orders identified Resident #2 was prescribed the following medications: a. Omeprazole 20 mg one tablet by mouth for GERD at 8:00 AM b. Atorvastatin 40 mg once a day by mouth for hyperlipidemia at 9:00 AM c. Apixaban .5 mg two times a day by mouth for knee arthroplasty at 9:00 AM d. Plaquenil 200 mg once a day by mouth for arthritis at 9:00 AM e. Anastrozole 1 mg once a day by mouth for breast cancer at 9:00 AM f. Metoprolol 50 mg once a day by mouth for hypertension at 9:00 AM g. Furosemide 40 mg once a day for congestive heart failure at 9:00 AM h. Sacubitril Valsartan 24-26 mg once a day by mouth for hypertension at 9:00 AM 2. Resident #1 was admitted to the facility with diagnoses that included fracture of the right femur, atrial fibrillation, epilepsy, hypertension and heart failure. Resident #1's allergies were oxycodone and the pneumococcal vaccine. The care plan dated 4/18/25 identified Resident #1 had the potential for altered cardiac status related to hypertension, congestive heart failure, atrial fibrillation, hyperlipidemia, hypotension and had a pacemaker. Interventions included vital signs per protocol and as needed. A physician's order dated 4/19/25 directed Metoprolol 25 mg tablet half tablet once a day for hypertension. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was independent with eating with set up help. A physician's order dated 4/24/25 directed Midodrine 5 mg two times a day for hypotension. A nursing note by RN #1 dated 4/30/25 at 10:30 AM identified Resident #1 received the following wrong medications: Omeprazole 20 mg, Atorvastatin 40 mg, Apixaban .5 mg, Plaquenil 200 mg, Anastrozole 1 mg, Metoprolol 50 mg, Furosemide 40 mg and Sacubitril Valsartan 24-26 mg. Resident #1's blood pressure dropped to 77/46 and Resident #1 was given fluids, Midodrine 5 mg and placed in Trendelenburg position. Resident #1's blood pressure was checked every 15 minutes, and the systolic blood pressure remained in the 80's. Resident #1 denied dizziness, lightheadedness, nausea, vomiting or headache. Resident #1 was able to take fluids without difficulty and remained alert and orientated. The APRN and MD were updated and ordered Resident #1 be transferred to the emergency department (ED) for further evaluation. The ED note dated 4/30/25 identified Resident #1 received a 1-liter bolus of normal saline at 10:57 AM. Poison control was contacted and were not concerned of potential drug interactions. They did not anticipate significant ill effects from the medications other than metoprolol, as the patient was likely prone to hypotension since he/she was prescribed Midodrine. A nursing note dated 4/30/25 at 8:10 PM identified Resident #1 returned to the facility. Resident #1 received 1500 ml of fluid and was stable at the ED. The accident and incident (A & I) form dated 4/30/25 at 8:45 AM identified Resident #1 was administered Resident #2's medications (his/her roommate) in error. Resident #1's blood pressure was monitored every fifteen minutes until transfer to the emergency department (ED). Vital sign monitoring was completed for all other residents on the floor. The medication administration record (MAR) identified on 4/30/25 at 9:00 AM midodrine 5mg was administered. Interview with LPN #1 on 5/14/25 at 11:23 AM identified she prepared medications for Resident #2 on 4/30/25 at the doorway of Resident #1's and Resident #2's room then entered the room and approached Resident #1. She asked Resident #1 if she was Mary and Resident #1 answered yes. She identified she did not check Resident #1's name identification bracelet but checked the picture in the medical record, which she thought looked like Resident #2. She identified she gave Resident #1 the cup of medications and did not tell Resident #1 what the medications were. Resident #1 then asked LPN #1 where her Keppra medication was. LPN #1 went back to the medication cart and found no order for Keppra then realized she administered the medications to the wrong resident. She turned to Resident #1 and he/she already swallowed the medications. She identified she could not find the supervisor to report the medication error so she told LPN #2 that Resident #1 received Resident #2's medications. She then took Resident #1's vital signs, gave Resident #1 fluids and midodrine, placed Resident #1 back into bed into Trendelenburg position. She identified that she continued with her medication pass, including given Resident #2 his/her prescribed medications. Resident #1 did not receive any other medications other than Midodrine. She identified she failed to ensure she had the right resident when administering medications. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 5/14/25 at 12:42 PM identified that around 9:00 AM on 4/30/25 she was notified by LPN #2 that LPN #1 gave Resident #1 50 mg of Metoprolol, not his/her prescribed amount of 12.5 mg. RN #1 identified she assessed Resident #1, his/her systolic blood pressure was 77 (normal systolic blood pressure is 120), and she notified the APRN. Resident #1 was given water, assisted into bed in Trendelenburg position, and blood pressure was monitored every fifteen minutes. She identified she reported the medication error to the DNS at morning report. The DNS asked her to verify the error and RN #1 then discovered Resident #1 received all of Resident #2's morning medications, not just the Metoprolol. The APRN was updated and ordered Resident #1 be sent to the ED. RN #1 identified LPN #1 continued the morning medication pass, as the error was not identified as significant when she was first notified. She identified all the residents LPN #1 administered medications to had their vital signs assessed. RN #1 identified residents should be verified by their name band, picture and date of birth for medication administration and if a resident does not have a name band on, another staff member should verify the resident. Interview with the DNS on 5/14/25 at 1:00 PM identified on 4/30/25 when LPN #1 identified the medication error, she could not find the supervisor so told LPN #2 that Resident #1 received the wrong blood pressure medication and was concerned about Resident #1's blood pressure. The DNS identified LPN #1 did not tell LPN #2 that Resident #1 received all of Resident #2's medications. LPN #2 reported the medication error to RN #1 who then reported the medication error to her (the DNS). It was then discovered that LPN #1 administered all of Resident #2's medications to Resident #1. LPN #1 had competed the medication pass at that time, and the DNS had her leave the building. She identified if she knew LPN #1 administered all of Resident #2's medications to Resident #1, they would have stopped LPN #1 immediately in her medication pass. She identified all other residents LPN #1 administered medications to had their vital signs assessed and were all stable. The DNS identified Resident #1 had a name identification band on for LPN #1 to verify the resident appropriately. She further identified two verifications should be used to identify a resident before medications are administered. Subsequent to the event, medication administration education for all staff was initiated on 4/30/25, LPN #1 was provided medication administration education from her agency and would not be returning to the facility, QAPI improvement plan was initiated on 4/30/25 with a target completion date of 6/1/25 and medication administration audits were initiated on 5/1/25. Review of the Medication Error Policy directed that a medication error is a discrepancy between what the healthcare provider ordered and what the resident received. Significant med error means one that causes an adverse effect to the resident (discomfort, jeopardized his/her health safety). Review of the Medication Pass policy directed to identify each resident prior to administration (picture, ID bracelet, etc.), know diagnosis and indication for every medication, do not pre-pour medication, administer them as they are prepared. Always observe the resident until they have swallowed all medications that have been administered, do not leave medication in med cup at bedside or tableside. It further directed to remember the six rights: right resident, drug, dose, dosage form, route and time.