

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Connecticut Baptist Homes, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 292 Thorpe Avenue Meriden, CT 06450	
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 - 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 the residents' medical records, facility documentation review, and interviews, it was determined that the facility failed to ensure that residents were free of significant medication errors. Specifically, the facility failed to administer correct medication to Resident #1 which led to harm and resulted in hospitalization with consequences. The findings include: Resident #1's diagnoses included diabetes mellitus, chronic kidney disease, lymphedema, asthma, neuropathy and hypertension. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was alert and oriented with no memory recall deficits. The Resident Care Plan dated 4/7/26 identified Resident #1 had altered cardiovascular status, impaired circulation and altered respiratory status. Interventions directed to administer medications per the physician's order. A physician's order dated 5/1/26 directed Resident #1 receive the following medications at 8:30 AM everyday: Daily-Vite tablet (a multivitamin) by mouth once a day, Fluticasone Propionate 50 microgram (mcg) spray give two (2) sprays into each nostril once a day (a medication for allergies), and Eliquis 2.5 milligram (mg) tablet by mouth every twelve hours (a medication to keep the blood from clotting). The Reportable Event Form dated 5/27/26 at 10:00 AM identified a licensed nurse who had pre-poured medications for two (2) residents (Resident #1 and Resident #2) and set the medication cups in the top drawer of the medication cart had failed to verify the correct medication cup was obtained to ensure Resident #1 did not receive Resident #2's medication, resulting in Resident #1 becoming hypotensive (low blood pressure) and dizzy requiring a transfer to the emergency department. The investigation identified Resident #1 was given the following medications Allopurinol 100 mg tablet by mouth (a medication used to treat gout), Aspirin 81 mg tablet by mouth, Metoprolol Succinate Extended Release (ER) 25 mg tablet (a medication used to treat high blood pressure), Olmesartan Medoxomil 40 mg tablet by mouth (a medication used to treat high blood pressure), and Pantoprazole Sodium 20 mg tablet (a medication used to treat gastroesophageal reflux disease). The nurse's note dated 5/27/26 at 2:44 PM identified Resident #1 received the wrong medication in the morning. The note indicated initially Resident #1's vital signs were within normal limits and Resident #1 was at his/her baseline alert and oriented mentation. The note identified after lunch Resident #1 complained of weakness, appeared ashen (pale), blood pressure readings decreased to 81/48 and 110/68 (normal blood pressure is 90-119/60-79) with a pulse rate of 77. The note identified the physician was notified, a new order was obtained to transfer Resident #1 to the Emergency Department (ED for evaluation and Resident was transferred at 1:30 PM. The Prehospital Care Report dated 5/27/26 identified at 1:38 PM Resident #1's blood pressure was 74/40, pulse 57 and respirations 16, a twelve (12) lead electrocardiogram (EKG) was obtained, and Resident #1 was found to be in sinus bradycardia (the heart beats fewer than 60 beats per minute). The hospital documentation identified Resident #1 was hypotensive in the Emergency Department with blood pressures in the 80's, Resident #1 responded well to fluids the blood pressure was stable, blood work was obtained and showed no significant electrolyte abnormalities, EKG interpretation was normal sinus rhythm, there was a discussion with poison control who recommended observation for eight (8) to twelve (12) hours. The note at 10:00 PM identified Resident #1 had remained stable since 5:00 PM and was ready for discharge with close monitoring. The nurse's (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 0760 Level of Harm - Actual harm Residents Affected - Few	note dated 5/28/26 at 5:24 AM identified Resident #1 had returned to the facility at 12:10 AM and vital signs were stable. Interview with the 7AM-3PM nursing supervisor, Registered Nurse (RN) #2, on 6/23/26 at 12:22 PM identified on 5/27/26 the 7AM-3PM charge nurse, RN #1, reported that she had given Resident #1 another resident's medications in error. Interview with RN #1 on 6/23/26 at 12:40 PM identified she usually administers the resident medication in the dining room. RN #1 explained on 5/27/26 she prepared Resident #2's medication then realized Resident #2 was not in the dining room, so she labeled the medication cup and put the cup in the top drawer. RN #1 identified Resident #1 rang for his/her medications, so she prepared Resident #1's medication and an emergency came up, so she labeled the cup and put the medication cup in the top drawer of the cart. RN #1 indicated after she returned from the emergency, Resident #1 was still ringing for his/her medications, she grabbed the wrong cup from the medication cart and gave Resident #1 another resident's medication, Resident #2. Interview with the Director of Nursing (DON) on 6/23/26 at 1:37 PM identified on 5/27/26 RN #1 administered Resident #2's morning medications to Resident #1 who became symptomatic after lunch and required a transfer to the ED for evaluation. The DON identified it is the facility's expectation that once a medication was removed from the blister pack, if it was not administered at that time, the medication should be thrown away and not placed in the medication cart for administration later. The DON identified RN #1 failed to follow the facility policy when she placed the dispensed medications of both Resident #1 and Resident #2 into the top drawer of the medication cart and then administered Resident #2's medications to Resident #1. Review of the facility policy (from Omnicare Pharmacy) titled General Dose Preparation and Medication Administration, last revised 11/15/24, directed, in part, prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. The policy further directed, in part, during medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: verify resident identity per facility policy (e.g. picture, armband, name), and verify the medication name and dose are correct.		