STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075423	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis Place	111 Westcott Rd Danielson, CT 06239

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, facility documentation and facility policy for two (2) of three (3) residents (Resident #2 and Resident #3) reviewed for Resident Care Plans (RCPs), the facility failed to update comprehensive RCPs to address the residents needs. The findings included: 1. Resident #2 was admitted to the facility in March of 2025 with diagnoses that included periprosthetic fracture around internal prosthetic left knee joint, pain in the left knee, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of seven (7) indicative of severely impaired cognition and required substantial assistance with eating, oral and personal hygiene and was dependent with transfers. The RCP dated 3/19/25 identified the potential for altered mood state and psychosocial well-being related to diagnoses of depression and adjustment to short term rehabilitation and administration of psychoactive medications. Interventions directed to administer medications per physician's orders, behavior tracking each shift, and monitoring for the therapeutic effect of medication. The RCP failed to identify Resident #2 had pain or was at risk for pain. A physician ' s order dated 3/19/25 directed Oxycodone HCl oral tablet, 5 milligrams (mg) one (1) tablet every three (3) hours as needed for moderate pain and two (2) tablets every three (3) hours as needed for severe pain. A physician's order dated 3/19/25 directed Morphine Sulfate ER oral tablet, 15 mg, give one (1) tablet every twelve (12) hours for pain. A note by APRN #2 dated 3/19/24 at 9:00 AM identified Resident #2 was found with Klonopin, Dialudid, and Percocet in his/her room that were not administered by the facility and staff reported Resident #2 had been more lethargic. A room search was completed (after obtaining permission) and controlled drugs were removed from the room. APRN #2 further identified Resident #2's morning dose of Klonopin was held, there was no current order for Dilaudid, the order for Oxycodone was reduced to one (1) tablet every three (3) hours for pain as needed to one (1) tablet every four (4) hours for pain as needed, and Resident #2 was educated on facility policy regarding unauthorized medications. A physician's order dated 3/20/25 directed Gabapentin 300 mg tablet three (3) times a day for pain. (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 3/21/25 directed Percocet, 5-325 mg tablet (Oxycodone with acetaminophen), give one (1) tablet by mouth every three (3) hours as needed for pain. May use until oxycodone is available. A physician's order dated 3/24/25 directed Percocet, 5-325 mg tablet (Oxycodone with acetaminophen), give one (1) tablet every four (4) hours as needed for pain. The March 2025 Medication Administration Report (MAR) identified Morphine Sulfate was administered 3/19/25 through 3/21/25 for a pain report of nine (9) [on a pain scale of one (1) to ten (10)], gabapentin was administered three (3) times a day 3/20/25 through 3/31/25, oxycodone was administered 3/19/25 through 3/22/25 for pain report of five (5) to nine (9) [on a pain scale of one (1) to ten (10)], and Percocet was administered 3/21/25 through 3/31/25 for pain report of four (4) to eight (8) [on a pain scale of one (1) to ten (10)]. A physician's order dated 4/7/25 directed Hydromorphone HCl oral tablet, 2 mg, one (1) tablet every six (6) hours as needed for pain report of four (4) to seven (7) [on a pain scale of one (1) to ten (10)], and two (2) tablets by mouth every six (6) hours as needed for pain greater than seven (7) [on a pain scale of one (1) to ten (10)]. Review of Resident #2's April 2025 MAR identified gabapentin was administered three (3) times a day 4/1/25 through 4/9/25, Hydromorphone 2 mg was administered once on 4/7/25 for a pain report of seven (7) [on a pain scale of one (1) to ten (10)], Hydromorphone 4 mg was administered 4/7/25 through 4/10/25 for pain report of eight (8) to ten (10) [on a pain scale of one (1) to ten (10)], and Percocet 5-325 mg was administered 4/1/25 through 4/6/25 for pain report of four (4) to eight (8) [on a pain scale of one (1) to ten (10)]. Review of the RCP failed to identify goals and interventions for pain management and failed to identify Resident #2 ' s use of unauthorized controlled drugs within the facility and coinciding interventions for monitoring. 2. Resident #3 was admitted to the facility in February of 2025 with diagnoses of dysphagia, epilepsy, and neurocognitive disorder with Lewy bodies. Hospital discharge documents dated 3/13/25 identified Resident #3 was hospitalized and treated for seizures and from 3/8/25 to 3/13/25 and treated for chronic myeloproliferative disorder/essential thrombocythemia (increased number and size of platelets in the blood). Review of the facility Nursing admission assessment dated [DATE] identified Resident #3 was transported from the hospital via stretcher with admitting diagnoses of seizures, diabetes mellitus, and dementia, was alert to person and place, verbally appropriate, anxious, and required extensive assistance with bed mobility, transfers, and toilet use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RCP dated 3/13/25 identified decreased cognition related to dementia, short term and/or long-term memory deficit, and administration of psychoactive medications. Interventions directed to review the following for possible causes of decline in cognition: medications, weight loss, medical problems, constipation, diarrhea, diabetes, and cardiac disease, and to administer medication per physician order. The RCP failed to identify goals and interventions for seizures and chronic myeloproliferative disorder (which required a new order for the administration of hydroxyurea and monitoring of blood cell and platelet counts) that were identified on the 3/13/25 hospital discharge record. Interview with the Director of Nursing Services (DNS) on 4/10/25 at 1:56 PM identified the RCP for Resident #2 should have been updated for pain management and unauthorized use of outside medications to prevent the risk of overdosing or drug to drug interactions. The DNS further identified updating the RCP would ensure continuity of care. Review of the Change in the Resident's Condition or Status policy directed a significant change of condition was a major decline or improvement in the residents' status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting) and requires interdisciplinary review and/or revision of the care plan. Review of the Care Plans, Comprehensive Person-Centered policy identified the comprehensive, person-centered care plan will describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, would incorporate risk factors associated with identified problems, reflect treatment goals, timetables, and objectives in measurable outcomes, identify the professional services that are responsible for each element of care, and aid in preventing or reducing decline in the resident's functional status and/or functional needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical records, interviews, facility documentation and facility policy for eleven (11) of sixteen (16) residents (Resident #8, #9, #10, #11, #13, #14, #15, #16, #18, #19, and #20) reviewed for physician's orders, the facility failed to ensure residents orders were reviewed and signed by the physician/advanced practice registered nurse monthly. The findings included: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses that included heart failure, anxiety and vascular dementia. Review of physician orders identified medical orders were reviewed and signed on 10/1/24, 12/31/24, and 3/11/25, however failed to identify medical orders were reviewed in 11/2024, 1/2025, and 2/2025 in accordance with facility practices. 2. Resident #9 was admitted to the facility on [DATE] with diagnoses that included systolic congestive heart failure, dementia, and anxiety. Review of physician orders identified medical orders were reviewed on 4/24/24, 7/17/24, 8/11/24, 9/11/24, 11/14/24, 1/22/25, and 3/18/25, however failed to identify medical orders were reviewed in 5/2024, 6/2024, 10/2024, 12/2024, and 2/2025 in accordance with facility practices. 3. Resident #10 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, spinal stenosis, and anxiety. Review of physician orders identified medical orders were reviewed on 4/24/24, 7/19/24, 8/11/24, 9/19/24, 1/22/25, and 3/18/25, however failed to identify medical orders were reviewed in 5/2024, 6/2024, 10/24 through 12/2024, and 2/2025 in accordance with facility practices. 4. Resident #11 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, major depressive disorder, and vascular dementia. Review of physician orders identified medical orders were reviewed on 4/8/24, 5/7/24, 7/8/24, 8/11/24, 9/19/24, 12/18/24, 1/14/25, and 3/11/25, however failed to identify medical orders were reviewed in 6/2024, 10/20245, 11/2024, and 2/2025 in accordance with facility practices. 5. Resident #13 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, vascular dementia, and recurrent major depressive disorder. Review of physician orders failed to identify medical orders were reviewed monthly from date of admission to current date (4/16/25). 6. Resident #14 was admitted to the facility on [DATE] with diagnoses that included transient cerebral ischemic attacks, dementia, and anxiety. Review of physician orders identified medical orders were reviewed on 7/29/24, 10/4/24, 2/25/25, and 4/8/24, however failed to identify medical orders were reviewed in 4/2024 through 6/2024, 8/2024, 9/2024, 11/2024 through 1/2025, and 3/2025 in accordance with facility practices. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Resident #15 was admitted to the facility on [DATE] with diagnoses that included myotonic muscular dystrophy, cardiomyopathy, and chronic pulmonary embolism. Review of physician orders identified medical orders were reviewed on 5/16/24, 6/18/24, 8/11/24, 10/4/24, and 2/18/25, however failed to identify medical orders were reviewed monthly in 7/2024, 9/2024, and 11/2024 through 1/2025, and 3/2025 in accordance with facility practices. 8. Resident #16 was admitted to the facility in 2017 with diagnoses that included heart failure, anxiety, and dementia with other behavioral disturbances. Review of physician orders identified medical orders were reviewed on 4/15/24, 5/16/24, 6/4/24, 8/11/24, 10/3/24, 1/17/24, and 2/18/24, however failed to identify medical orders were reviewed monthly in 7/2024, 9/2024, 11/2024, 12/2024, and 3/2025 in accordance with facility practices. 9. Resident #18 was admitted to the facility on [DATE] with diagnoses that included chronic ischemic heart disease, vascular dementia, and other recurrent depressive disorders. Review of physician orders identified medical orders were reviewed on 4/3/24, 5/7/24, 6/3/24, 8/11/24, 10/2/24, 2/18/25, and 4/9/25, however failed to identify medical orders were reviewed monthly in 7/2024, 9/2024, 11/2024 through 1/2025, and 3/2025 in accordance with facility practices. 10. Resident #19 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, complete atrioventricular block, and adjustment disorder. Review of physician orders identified medical orders were reviewed on 4/8/24, 5/7/24, 6/13/24, 8/11/24, 9/13/24, 12/31/24, 2/4/25, and 4/15/25, however failed to identify medical orders were reviewed monthly in 7/2024, 10/2024, 11/2024, 1/2025, and 3/2025 in accordance with facility practices. 11. Resident #20 was admitted to the facility on [DATE] with diagnoses that included adjustment disorder, dementia, and unspecified mood disorder. Review of physician orders identified medical orders were reviewed on 8/11/24, 11/19/24, 1/3/25, 2/4/25, and 3/11/25, however failed to identify medical orders were reviewed monthly in 9/2024, 10/2024, and 12/2024 in accordance with facility practices. Interview with the Assistant Director of Nurses (ADNS) on 4/14/25 at 11:00 AM identified either the physician or advance practice registered nurse were responsible for reviewing medical orders monthly and the facility's standard of practice was to have the physician's review and sign the resident's medical orders monthly. The ADNS failed to identify the reason why this did not occur. The facility was unable to provide a policy detailing the frequency the physician's orders were to be reviewed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documentation and policies for one (1) of five (5) residents (Resident #3) reviewed for orders, the facility failed to ensure a physician's inquiry to a lab result was responded to timely and that lab results were forwarded to all pertinent physician's in a timely manner, and for one (1) of three (3) residents reviewed for medication administration, the facility failed to ensure that a resident was administered an antibiotic in accordance with physician's orders. The findings included: 1. Resident #3 was admitted to the facility February 2025 with diagnoses of dysphagia, epilepsy, and neurocognitive disorder with Lewy bodies. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of seven (7) indicative of severely impaired cognition and required substantial assistance with eating, oral and personal hygiene and was dependent with transfers. (If an assessment is needed that was closer to the readmission date of 3/13/25, we can use the Nursing admission Assessment). Review of the Nursing admission assessment dated [DATE] identified Resident #3 was transported from the hospital via stretcher with admitting diagnoses of seizures, diabetes mellitus, and dementia, was alert to person and place, verbally appropriate, anxious, and required extensive assistance with bed mobility, transfers, and toilet use. Review of Resident #3's revised Care Plan dated 3/13/25 identified decreased cognition related to dementia, short term and/or long-term memory deficit, and administration of psychoactive medications. Interventions directed to review the following for possible causes of decline in cognition: medications, weight loss, medical problems, constipation, diarrhea, diabetes, and cardiac disease, and to administer medication per physician order. Review of Resident #3's hospital discharge record dated 3/13/25 identified Resident #3 was treated for chronic myeloproliferative disorder/essential thrombocythemia (increased number and size of platelets in the blood) and directed continued administration of Hyroxyurea at the facility. Review of APRN #2's note dated 3/14/25 at 11:30 AM identified Resident #3 was found to have leukocytosis during his/her 3/8/25 to 3/13/25 hospitalization, was followed by hematology for myeloproliferative disorder and thrombocytopenia, had his/her hydroxyurea (medication used to reduce platelet count) reinstated at home doses, and that his/her CBC (complete blood count) and BMP (basal metabolic panel) would be drawn with results forwarded to hematology/oncology. A physician's order dated 3/14/25 directed CBC and BMP on every night shift, every Monday, Wednesday, and Friday for anemia and thrombocytopenia. Review of Resident #3's labs records identified CBC and BMP labs were drawn on 3/14/25, 3/17/25, 3/19/25, 3/21/25, 3/24/25, 3/26/25, and 3/28/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of Resident #3's 3/26/25 lab report identified the facility had faxed the lab results [which included a white blood cell count (WBC) of 1.46 and platelet count of 225] to MD #1, noting the facility had initiated neutropenic precautions and that labs were faxed to the Hematologist/Oncologist. Interview with MD #1 on 4/16/25 at 9:14 AM identified he/she had asked the facility for Resident #3's current hydroxyurea dose via fax at 2:52 PM on 3/26/25 as Resident #3's WBC count was 1.46 and platelet count was 225, and did not receive a response to his/her request. MD #1 further indicated, upon receiving the results from labs drawn on 3/28/25, which indicated a WBC count of 0.99 and platelet count of 129, he/she chose to call the facility with orders to hold the hydroxyurea instead of faxing the request. MD #1 indicated a WBC count of less than 2.0 would be concerning and that a drop in Resident #3's WBC count was a side effect of hydroxyurea. b. Interview with APRN #1 (Hematology and Oncology Advanced Practice Registered Nurse) on 4/15/25 at 10:45 AM identified the facility did not always forward lab draw results timely. APRN #1 further indicated the lab draw results dated 3/14/25 and 3/17/25 were received on 3/19/25, lab results dated 3/24/25 were received on 3/26/25, lab results dated 3/26/25 were received on 3/27/25, and that the lab results for lab draws dated 3/19/25, 3/21/25, and 3/28/25 were never received. Interview with the Assistant Director of Nurses on 4/16/25 at 8:31 AM identified the facility's standard of practice was for the nursing supervisor to respond to the physican's faxes immediately regarding any resident related concern or information requested and that the response should occur during the shift the fax was received. The ADNS further identified it was the responsibility of the nursing supervisor on 1 [NAME] to receive faxes and distribute them as addressed. Although requested, the facility was unable to provide a policy regarding physician communications/faxes. 2. Resident #4 was admitted to the facility in May 2020 and had diagnoses that included unspecified dementia, Type 2 diabetes mellitus, and recurrent major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of eight (8) indicative of moderate cognitive impairment. The MDS further identified Resident #4 required substantial assistance with upper body dressing, personal hygiene and was dependent with transfers. Review of Resident #4's Care Plan dated 9/18/24 identified impaired cognition related to the diagnoses of alcohol-induced persisting dementia and diagnoses of vascular dementia, and arteriosclerotic heart disease, hyperlipidemia, hypertension, and advanced kidney disease/failure. Interventions directed to provide assistance with activities of daily living as needed, and administer medications as ordered. A physician's order dated 10/10/24 directed Levaquin oral tablet, 750 milligrams, one tablet by mouth at bedtime for pneumonia for seven (7) days. Review of the Medication Error Report dated 10/11/24 identified Resident #4 was not administered his/her 750 milligrams dose of Levaquin the evening of 10/10/24 and was left unattended on his/her bedside table. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Director of Nurses (ADNS) on 4/15/25 at 10:30 AM identified Resident #4 was supposed to be administered his/her first dose of Levaquin on 10/10/24 at 9:00 PM and wasn't as the medication was found on Resident #4's bedside table the following morning by LPN #2. The ADNS identified the standard of practice was to administer medications in accordance with physician's orders, to watch the resident take the medication and not leave his/her bedside until the medication was swallowed. The ADNS further indicated that Resident #4 was not able to self-administer medications and that the Levaquin 750 milligram order was extended to allow for the full seven (7) day course to be administered. Interview with LPN #2 on 4/16/25 at 8:42 AM identified he/she noticed a medication cup on Resident #4's bedside table on 10/11/24 with an unfamiliar medication in it and suspected it was Levaquin, which Resident #4 was to have taken on second shift the night before. LPN #2 indicated he/she removed the medication from Resident #4's room, identified that it was Levaquin, and had reported the incident to the nurse supervisor. Review of the Medication Administration policy directed medications to be administered in a safe and effective manner.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, facility documentation and facility policy for one (1) of three (3) residents (Resident #3) reviewed for medication errors, the facility failed to prevent a significant medication error by failing to accurately transcribe and verify Provider's orders for a resident readmitted to the facility. This failure resulted in the finding of Immediate Jeopardy. The findings include: Resident #3 received 30,000 mg of Hydroxyurea in excess from the hospital order which resulted in a hospitalization due to critical lab values (lab value date range: 3/14/25 through 3/28/25) which identified decreasing white blood cell (WBC) values from 12.62 to 0.99 (normal range 4.5 to 11) and decreasing platelet values from 962 to 129 (normal range 150 to 450). Resident #3 was admitted to the facility in February of 2025 with diagnoses which included dysphagia, epilepsy, and neurocognitive disorder with Lewy bodies. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) score of seven (7) indicative of severely impaired cognition and required substantial assistance with eating, oral and personal hygiene and was dependent with transfers. The Resident Care Plan dated 3/13/25 identified decreased cognition related to dementia and short term and/or long-term memory deficit. Interventions included to review the following for possible causes of decline in cognition: medications, medical problems, diabetes, and cardiac disease, to administer medication per physician order, and monitor resident for therapeutic effect of medication. A hospital Discharge summary dated [DATE] identified the following orders: -Hydroxyurea, 100 milligrams (mg)/milliliter (ml) suspension, ten (10) ml (1,000 mg total) by gastrostomy tube route four (4) times a week on Saturday, Sunday, Tuesday, and Thursday. -Hydroxyurea, 100 mg/ml suspension, five (5) ml (500 mg total) by gastrostomy tube route three (3) times a week on Monday, Wednesday, and Friday. Facility Physician's orders dated 3/13/25 identified the following orders: -Hydroxyurea oral capsule, 500 mg, give one (1) capsule via gastrostomy tube three (3) times a day every Monday, Wednesday, and Friday for chemotherapy. -Hydroxyurea oral capsule, 500 mg, give two (2) capsules via gastrostomy tube four (4) times a day every Tuesday, Thursday, Saturday, and Sunday for chemotherapy. Review of the March 2025 Medication Administration Report identified Resident #3 was administered 500 mg of hydroxyurea three (3) times daily (1,500 mg per day) on 3/14/25, 3/17/25, 3/19/25, 3/21/25, 3/24/25, and 3/26/25 and 1000 mg of hydroxyurea four (4) times daily (4,000 mg per day) on 3/15/25, 3/16/25, 3/18/25, 3/20/25, 3/22/25, 3/23/25, 3/25/25, and 3/27/25. (A total of 41,000 mg of hydroxyurea was administered over a 14-day period which was 30,000 mg in excess of what the hospital ordered.) (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing note by RN #2 on 3/30/25 at 2:21 PM identified Resident #3 had a change of condition, a rectal temperature of 102.5, ten (10) out of ten (10) gastrointestinal discomfort, a non-productive cough, and pale appearance. Resident #3 requested to be sent to the hospital as he/she didn't feel well, the physician was informed, and Resident #3 was transferred to the hospital. The hospital Discharge summary dated [DATE] identified Resident #3 was admitted to the hospital on [DATE] with a neutropenic fever and diagnosed with Covid-19, Norovirus, recurrent Clostridium Difficile, and diverticulitis. Labs drawn on 3/30/25 identified a WBC count of 1.2, platelet count of 119, and notation that Resident #3 was critically ill with a high probability of imminent or life-threatening deterioration. The summary indicated Resident #3 was administered Nivestym twice (to stimulate WBC production) with improvement in WBC count and was treated with both IV and oral antibiotics for neutropenic fever. Resident #3 was discharged from the hospital on 4/8/25 to home with palliative care. Interview with RN #1 (Nurse Supervisor on the 3:00 PM to 11:00 PM shift) on 4/14/25 at 12:21 PM identified he/she entered the medications listed on Resident #3's hospital discharge summary into the electronic medical record (EMR) on 3/13/25 after verifying the medications on the hospital discharge summary with the facility physician. Upon entering the orders into the EMR, RN #1 indicated he/she correctly matched the dose of hydroxyurea with the day of the week it was supposed to be administered, however failed to enter the correct number of doses to be administered (instead of one (1) 500 mg dose of hydroxyurea on Monday, Wednesday, and Friday it was entered as three (3) 500 mg doses on those days and instead of one (1) 1000 mg dose of hydroxyurea on Tuesday, Thursday, Saturday, and Sunday it was entered as four (4) 1000 mg doses on those days). Interview with MD #1 on 4/14/25 at 3:06 PM identified he/she signed Resident #3's medication orders following his/her readmission to the facility on 3/13/25 and believed the orders were entered accurately prior to signing them. MD #1 further identified that he/she was unaware Resident #3 was receiving that much hydroxyurea at the facility and that the difference between what the hospital ordered and what was being administered at the facility was a significant medication error for a toxic drug that was known to have significant side effects. Interview with the Assistant Director of Nurses (ADNS) on 4/15/25 at 10:15 AM identified that when entering admission/readmission orders into the EMR, the nurse supervisor should confirm the hospital discharge summary orders with a provider, enter the orders into the EMR, and a second nurse should reconcile the hospital discharge summary orders and EMR to verify accuracy. The ADNS further indicated that expanding the EMR order to view the entire order detail was part of the verification process (to verify dose, frequency and schedule) and should have been done when verifying each order. Interview with the Hematology/Oncology Advanced Practice Registered Nurse (APRN #1) on 4/15/25 at 10:45 AM identified the hydroxyurea doses administered to Resident #3 were administered at a toxic and excessive dose, suppressed Resident #3's bone marrow production of WBCs and platelets, and weakened Resident #3's immune system, making him/her susceptible to infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075423	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis Place	111 Westcott Rd Danielson, CT 06239

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physician's Orders-Oral, Telephone, and Written policy directed the nurse would transcribe oral, telephone, and written orders from the Physician's orders sheet into the electronic medical record (EMR), orders would be noted on the Physician's Orders sheet by the nurse after entering them (unless the document was a Hospital Transfer sheet), and that the nurse would question, and not accept any order which was perceived as unsafe, contra-indicated or was not clear, and would raise the issue with the ordering physician, advanced practice registered nurse or physician assistant. Although requested, the facility was unable to provide a transcription/verification process policy. The Immediate Jeopardy template was presented to the Administrator by the State Agency on 4/15/25 at 2:44 PM. The facility submitted a removal plan which included education of all nursing staff to include medication transcription and verification, timely communication of lab results to the provider(s) and documentation of provider response/new order, enhanced auditing of new admission medication orders thirty (30) days prior to the event (March 1, 2025 to March 31, 2025), biweekly QAPI meeting for ninety (90) days or until substantial compliance was achieved, development of a list of residents currently prescribed chemotherapy medications and validation of current accuracy of medications in relation to orders, policy development related to the management and monitoring of residents on chemotherapy drugs, and policy development related to communication of lab results to Provider(s) and consultants which was accepted by the State Agency on 4/15/25 at 5:22 PM during an on-site visit.