| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205134 | A. Building<br>B. Wing | 03/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Joseph's Rehabilitation and Residence | 1133 Washington Ave<br>Portland, ME 04103 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>37015<br><br>Based on record reviews and interviews, the facility failed to ensure a resident was free from a significant medication error when controlled medications were administered in excess of prescribed doses ordered by a physician for 1 of 3 (#3).<br><br>Finding:<br><br>On 3/4/25, during a review of medication error reports, a report for Resident #3 was noted which stated, It was reported to this writer that last evening around 8:30 p.m., on 2/12/25, that at least 2 of resident's medications were administered twice, pregabalin 75 mg (milligrams) and oxycodone 10 mg. These were signed out of the narcotic/control book for 1904 (7:04 p.m.), but the nurse that signed it out had left facility earlier in the shift around 5:30 p.m.- 6:00 p.m. Medications were not signed out in EMAR (electronic medication administration record). Med tech (medication technician) reported that Nurse (#2) reported that Nurse (#1) had given medications before he/she left for the night. Med tech had given bedtime medications before this as medication administration was not passed on to med tech. Further concerns were noted that Resident #3 may have received double doses of bedtime medications. The report indicated that on 2/13/25, the resident's provider was notified of the error, as well as the resident's guardian.<br><br>A review of Resident #3's clinical record noted Physician block orders, signed on 2/10/25 included Pregabalin 75 mg by mouth twice daily, and Oxycodone 10 mg by mouth 3 times daily. A review of the EMAR noted these medications were administered on 2/12/25 at bedtime and signed by the medication technician. A review of the facility's controlled medication (bound) book, confirmed both medications had been signed out as given on 2/12/25 at 19:04 by Nurse #1 and also on 2/12/25 at 19:00 by the med tech.<br><br>Resident #3's clinical record contained a progress note dated 2/13/25 at 12:12 p.m., which stated It was reported that resident received at least an additional dose of Lyrica and Oxycodone last evening on 2/12/25. Medications were signed out in narcotic and control book at 1900 but staff member who signed out left facility early. Med tech unknowingly gave all HS (bedtime) medications as did not realize that nurse who left early had reportedly given them. Another nurse reported to med tech around 8:30 p.m., that the nurse who left had given HS medications but did not sign them out. This writer was notified on 2/13/25 at 7:00 a.m.<br><br>(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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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/13/25, a provider evaluated Resident #3 and stated, seen today for medication error. Nursing notified me this morning that nursing had given duplicate night medications last night. This included additional dose of Lyrica 75 mg and oxycodone 10 mg definitively as these were signed out of narcotic count. The provider note stated facility staff strongly believed that he/she received additional doses of bedtime medications. Vitals with tachycardia 108-112 (beats per minute) but otherwise stable. As a result of the error, the provider ordered increased staff monitoring of vital signs, an electrocardiogram, and lab work.<br><br>On 3/5/25, in an interview with a surveyor, Nurse #2 stated that when Nurse #1 left early on 2/12/25, he/she stated all the medications for Resident #3 had been given, and within that time, the med tech had given (Resident #2) the oxycodone. (Nurse #1) did not sign off the meds, so the med tech thought it was not given. The surveyor asked if staff can view residents' medications when they are not due on the electronic medical record (EMAR). Nurse #2 stated when a resident's name is pulled up, all the meds ordered for the day are listed. A medication is highlighted yellow and able to be signed off 1 hour before and after the time it is due to be given.<br><br>On 3/6/25 at 2:14 p.m., in a telephone interview with a surveyor, Nurse #1 stated he/she had given Resident #3 medication outside of the window prescribed by the doctor. Nurse #1 stated the resident had requested medication for pain, and that the medication as ordered, did not adequately address the pain. Nurse #1 stated when he/she left early on 2/12/25 at 6:00 p.m., he/she told the charge nurse (Nurse #2) to contact the resident's physician to have the medication order changed. Nurse #1 stated he/she had signed all medications administered in residents' EMARs but had not signed the controlled medications given to Resident #3, as it was before the 1 hour administration window and the EMAR was locked.<br><br>A review of the facility's policy, 6.0 General Dose Preparation and Medication Administration, with a revision date of 1/1/13, stated Section 5. During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 5.5 Document the administration of controlled substances in accordance with applicable law; 6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g., when medications are given) on appropriate forms.<br><br>On 3/7/25 at 9:50 a.m., in a telephone interview with the Clinical Services Director, the surveyor confirmed that Nurse #1 had failed to follow accepted standards of practice for medication administration, resulting in Resident #3 receiving additional doses of prescribed medications. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>37015<br><br>Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for medication errors (Resident #3).<br><br>Finding:<br><br>On 3/4/25, during a review of medication error reports, a surveyor noted on 2/13/25, a report for Resident #3 which stated, It was reported to this writer that last evening around 8:30 p.m., on 2/12/25, that at least 2 of resident's medications were administered twice, pregabalin 75 mg (milligrams) and oxycodone 10 mg. These were signed out of the narcotic/control book for 1904 (7:04 p.m.), but the nurse that signed it out had left facility earlier in the shift around 5:30 p.m. - 6:00 p.m. Medications were not signed out in EMAR (electronic medication administration record). Med tech (medication technician) reported that Nurse (#2) reported that Nurse (#1) had given medications before he/she left for the night. Med tech had given bedtime medications before this as medication administration was not passed on to med tech. Further concerns were noted that Resident #3 may have received double doses of bedtime medications. The report indicated that on 2/13/25, the resident's provider was notified of the error, as well as the resident's guardian.<br><br>A review of Resident #3's clinical record noted he/she was admitted in March, 2023. Physician block orders, signed on 2/10/25 included Pregabalin 75 mg by mouth twice daily, and Oxycodone 10 mg by mouth 3 times daily. A review of the EMAR noted these medications were administered on 2/12/25 at bedtime and signed by the medication technician. A review of the facility's controlled medication (bound) book, confirmed both medications had been signed out as given on 2/12/25 at 19:04 by Nurse #1 and also on 2/12/25 at 19:00 by the med tech.<br><br>On 3/4/25 at 3:00 p.m., in an interview with a surveyor, the Nurse Manager stated that Nurse #1 had not signed out that he/she had given the oxycodone at 19:04, but he/she left at 6 pm. The only way we knew it happened was he/she did sign it out in the bound book. He/she didn't sign out on the EMAR. The person following him/her discovered it when they were doing count after he/she had left. We suspected (the resident) got all his/her meds in duplicate. We are only sure of the ones he/she signed out - the oxycodone and the Lyrica (pregabalin). Those were due at bedtime.<br><br>A review of the facility's policy, 6.0 General Dose Preparation and Medication Administration, with a revision date of 1/1/13, stated Section 5. During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 5.5 Document the administration of controlled substances in accordance with applicable law; 6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g., when medications are given) on appropriate forms.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/6/25 at 1:36 p.m., in a telephone interview with a surveyor, the Director of Clinical Services confirmed that Nurse #1 had not followed the facility's policy for medication administration when he/she didn't sign Resident #3's EMAR for administration of the controlled medications before leaving. |