| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225133 | A. Building<br>B. Wing | 02/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Blueberry Hill Rehabilitation and Healthcare Ctr | 75 Brimbal Avenue<br>Beverly, MA 01915 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>37342<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #2), the Facility failed to ensure they notified his/her medical provider of a medication incident, when on 12/25/24, his/her morning medications were administered well over one hour later than the prescribed times, and his/her scheduled morning and afternoon Clonazepam (antipsychotic) doses were administered at the same time.<br><br>Findings include:<br><br>The Facility's Policy, titled Change in a Resident's Condition or Status, dated as revised 02/2021, indicated the Facility would notify the resident's physician when there had been an accident involving the resident.<br><br>The Facility Policy, titled Medication Errors, dated 09/2021, indicated all medication errors would be immediately reported to the resident, the resident's responsible party, and the prescriber, and also indicated medication errors included failure to administer a medication, administration of the wrong amount of medication, and failure to administer a medication at the prescribed time<br><br>The Facility Policy, titled Administering Medications, dated 2001, indicated medications would be administered in a safe and timely manner, as prescribed, and within one hour of their prescribed times.<br><br>Resident #2 was admitted to the Facility in July 2024, diagnoses included schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), hypertension, chronic kidney disease, and dysphagia (difficulty swallowing).<br><br>Resident #2's Medication Administration Record (MAR), dated 12/25/24 indicated he/she was scheduled to have the following medications administered between 09:00 A.M., and 10:00 A.M.:<br><br>-Aspirin, 81 milligram (mg) capsule<br><br>-Famotidine (treats heartburn), 20 mg tablet<br><br>-Invega (antipsychotic), 9 mg extended release tablet<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -MagOx (magnesium oxide supplement, also used as a laxative), 400 mg tablet<br><br>-MiraLax (laxative) oral packet, 17 grams (GM)<br><br>-Olanzapine (antipsychotic) 5 mg tablet<br><br>-Depakote Sprinkles 125 mg delayed release capsule, administer 500 mg (four capsules)<br><br>-Sennosides-Docusate Sodium (combination stool softener and laxative) tablet 8.6-50 mg<br><br>-Clonazepam (antipsychotic) 1 mg tablet, administer one tablet by mouth three times daily, scheduled for 10:00 A.M., 02:00 P.M., and 06:00 P.M.<br><br>During an interview on 02/19/25 at 10:10 A.M., Nurse #1 said that on 12/25/24, around 01:00 P.M., he and Nurse #2 identified a medication error, and that they had discovered that he (Nurse #1) had administered Resident #2's morning medications to another resident, in error. Nurse #1 said he then prepared Resident #2's morning medications again around 01:30 P.M., and administered Resident #2's scheduled morning medications to him/her. Nurse #1 said he also administered Resident #2's scheduled 02:00 P.M., Clonazepam 1 mg, to him/her at the same time. Nurse #1 said he did not notify Resident #2's on call medical provider of the late administration of the morning medications or that he had administered both the morning and afternoon Clonazepam doses at the same time.<br><br>During a telephone interview on 02/19/25 at 12:35 P.M., Physician #1 said he would not have given Resident #2 his/her morning and afternoon medications all at one time, especially his/her two doses of Clonazepam, as the increased dose could have caused him/her to develop lethargy and to become unresponsive. Physician #1 said he would expect nursing staff to report late medication administration to the on-call medical provider to obtain new orders.<br><br>During an interview on 12/19/25 at 08:35 A.M., The Director of Nurses said that on 12/25/24 Nurse #1 should have notified Resident #2's on-call medical provider of the late medication administration before administering his/her morning medications, but had not. |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>37342<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure he/she was free from a significant medication error, when on 12/25/24, Resident #1 was administered his/her scheduled medications in the morning by his/her assigned nurse and then Nurse #1, administered another resident's medications to Resident #1 in error. Several hours later Resident #1 experienced a significant change in condition, was disoriented and became lethargic, was transferred to the Hospital Emergency Department (ED), and was admitted to the Hospital for four days due to an accidental drug overdose.<br><br>Findings include:<br><br>The Facility Policy, titled Medication Errors, dated 09/2021, indicated all medication errors would be immediately reported to the resident, the resident's responsible party, and the prescriber, and also indicated medication errors were defined as one of the following:<br><br>-Failure to administer a medication<br><br>-Administration of the wrong medication<br><br>-Administration of the wrong amount of medication<br><br>-Failure to administer a medication at the prescribed time<br><br>-Administration to the wrong resident<br><br>-Administration through the wrong route.<br><br>The Facility Policy, titled Administering Medications, dated 2001, indicated:<br><br>- Medications would be administered in a safe and timely manner, as prescribed, and within one hour of their prescribed times.<br><br>- The nurse administering the medications would verify the resident's identity before giving the medication to him/her, and methods of identifying the resident included checking his/her identification wrist band, checking the photograph attached to his/her medical record, and if necessary, verifying the resident identification with other Facility personnel.<br><br>Resident #1 was admitted to the Facility in December 2023, diagnoses included hypertension (high blood pressure), altered mental status, paranoid personality disorder, and mild neuro-cognitive disorder.<br><br>Review of Resident #1's Medication Administration Record (MAR), dated 12/25/24, indicated he/she was administered the following scheduled medications between 09:00 A.M., and 10:00 A.M.:<br><br>-Amlodipine (antihypertensive), 5 milligrams (mg) tablet.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Aspirin (anti platelet), 81 mg chewable tablet.<br><br>-Finasteride (genitourinary agent), 5 mg tablet.<br><br>-Sennosides (stool softener), 8.6 mg tablet.<br><br>-Depakote (for mood regulation), 250 mg delayed release tablets, two tablets (500 mg)<br><br>-Quetiapine Fumarate (antipsychotic), 25 mg tablet.<br><br>Resident #2 was admitted to the Facility in July 2024, diagnoses included schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges) , hypertension, chronic kidney disease, and dysphagia (difficulty swallowing).<br><br>Resident #2's MAR, dated 12/25/24 indicated he/she was scheduled to have the following medications administered:<br><br>-Aspirin, 81 mg capsule.<br><br>-Famotidine (treats heartburn), 20 mg tablet.<br><br>-Invega (antipsychotic), 9 mg extended release tablet.<br><br>-MagOx (magnesium oxide supplement, also used as a laxative), 400 mg tablet.<br><br>-MiraLax (laxative) oral packet, 17 grams (GM).<br><br>-Olanzapine (antipsychotic) 5 mg tablet.<br><br>-Depakote Sprinkles 125 mg delayed release capsule, administer four capsules (500 mg).<br><br>-Sennosides-Docusate Sodium (combination stool softener and laxative) tablet 8.6-50 mg.<br><br>-Clonazepam (antipsychotic) 1 mg tablet.<br><br>Resident #1 and Resident #2 both resided on the Hale unit of the Facility and shared a common first name, however Resident #1 used a nickname.<br><br>Review of the Facility's internal investigation synopsis, undated, completed by the Director of Nurses, indicated that on 12/25/24 at 11:00 A.M., Nurse #1 administered Resident #2's morning medications to Resident #1, in error. The Synopsis indicated that on that same day at 01:00 P.M., Resident #1 was assessed as having had a change in condition, was lethargic and disoriented, and when Nurse #1 heard Nurse #2 refer to Resident #1 by another name (his/her nickname), Nurse #1 recognized that a medication error had occurred. The Synopsis indicated Resident #1 was transferred to the Hospital ED for evaluation.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #1's Hospital ED History and Physical, dated 12/25/24, indicated he/she was transferred to the ED via 911, was somnolent and mumbling, his/her heart rate was 43 beats per minute (slow, normal heart rate range is between 60 to 100 beats per minute), and was admitted to the Hospital with diagnosis of accidental drug overdose.<br><br>During a telephone interview on 02/19/25 at 10:10 A.M., Nurse #1 said that on 12/25/24 he was Resident #2's assigned nurse. Nurse #1 said that on 12/25/24 around 11:00 A.M., he prepared Resident #2's morning medication, and went to the unit dining room where several residents were in an activity, and called out Resident #2's name. Nurse #1 said a resident (later identified as Resident #1) responded to Resident #2's name. Nurse #2 said the resident resembled the picture that was in Resident #2's medical record, so he administered the medications to him/her, as he believed that he/she was Resident #2.<br><br>However, Nurse #1 had actually administered Resident #2's morning medications to Resident #1, who had already been administered his/her own scheduled morning medications early that day by Nurse #2.<br><br>Nurse #1 said he was not familiar with the residents on the unit, and said he did not look for an identification bracelet, because at the time, most residents did not have one anyway. Nurse #1 also said he did not ask any other staff members working on the unit to help him identify Resident #2.<br><br>Nurse #1 said around 01:00 P.M. (on 12/25/24), Resident #1 was returned from the main dining room by Activities Aide #1, and that he/she was sleepy and dizzy. Nurse #1 said he heard Nurse #2 call Resident #1 by his/her nickname, said he asked Nurse #2 to clarify who Resident #1 was, and said that was when he realized he had administered Resident #2's medications to Resident #1, in error.<br><br>During an interview on 02/19/25 at 10:57 A.M., Nurse #2 said that on 12/25/24 she was Resident #1's assigned nurse. Nurse #2 said she had administered Resident #1's scheduled morning medications between 09:00 A.M., and 10:00 A.M., that morning. Nurse #2 said Resident #1 had been at his/her baseline and that he/she was his/her normal self until around 01:00 P.M., when Activities Aide #1 brought Resident #1, who normally ambulated, back to the unit in a wheelchair from the main dining room. Nurse #2 said Resident #1 had a change in mental status, was lethargic and unsteady on his/her feet.<br><br>Nurse #2 said when she assessed Resident #1, she called him/her by his/her preferred nickname, and that Nurse #1 then asked her to clarify who Resident #1 was. Nurse #2 said Nurse #1 then told her that he had administered Resident #2's morning medications to Resident #1 in error.<br><br>Review of Resident #1's Nurse Progress Note, dated 12/25/24, indicated Resident #1 was accidentally administered Resident #2's morning medications, and later had a change in condition, became disoriented, and his/her speech was unclear. The Note indicated that Nurse Practitioner #1 was notified of the medication error, Resident #1's change in condition, and an order was obtained to transfer Resident #1 to the Hospital ED.<br><br>During an interview on 02/19/25 at 08:35 A.M., the Director of Nurses (DON) said Nurse #1 should have identified Resident #2 before administering his/her medications, but had not, and instead administered Resident #2's medications to Resident #1 in error. |