STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225137	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dexter House Healthcare	120 Main Street Malden, MA 02148

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #2), the Facility failed to ensure he/she was free from a significant medication error, when on 08/07/25, Nurse #1 administered Epinephrine (hormone that increases adrenaline) to him/her instead of Glucagon (hormone that increases blood glucose level), in error.Findings include: The Facility Policy, titled Administering Medications, dated as revised 09/2024, indicated, the individual who administered medications would check the label to verify the right resident, right medication, right dosage, right time, and right route of administration before giving the medication. Resident #2 was admitted to the Facility in July 2025, diagnoses included left femur fracture, hypertension, and diabetes.Review of Resident #2's Hospital Discharge summary, dated [DATE], indicated that on 08/07/25, while at the Facility, Resident #2 experienced a change in mental status, was assessed by nursing, and found to have a blood glucose level of 59 milligrams/deciliter (mg/dl) (low). The Hospital Discharge Summary indicated that the Facility nurse attempted to administer a Glucagon injection, however, administered an EpiPen injection, by mistake.Review of Resident #2's Order Summary Report indicated he/she had a Physician's order, dated 07/08/25, to administer Glucagon (a hormone produced by the pancreas that plays a crucial role in regulating blood sugar levels by increasing glucose concentration in the bloodstream) 1 milligram (mg) intramuscularly (IM) as needed for blood sugar less than 70 mg/dl if he/she was not responsive or not able or willing to swallow.Further review of Resident #2's Order Summary indicated he/she did not have a physician's order for Epinephrine.Review of the Facility's Emergency Kit Contents List, located one kit on each unit, indicated the kit contained the following:-Gvoke (Glucagon) 1mg per 0.2ml Hypopen injection.-Epinephrine (EpiPen, also known as adrenaline, is both a neurotransmitter and a hormone. It plays an important role in your body's fight-or-flight response. It's also used as a medication to treat many life-threatening conditions) 0.3mg per 0.3 milliliters (ml) injection.According to Mayoclinic.org, serious side effects of Epinephrine include increased blood pressure, which can lead to heart attack or stroke, as well as vomiting, tremors, and seizures. During an interview on 09/02/25 at 03:44 P.M., Nurse #1 said that on 08/07/25 at 10:00 P.M., she was alerted by another staff member that Resident #2 had a change in mental status and was shaking. Nurse #1 said Resident #2's blood glucose level was 59 mg/dl (low). Nurse #1 said she used her cell phone to call 911 while she tried giving him/her orange juice with sugar mixed in it, however he/she was unable to drink it. Nurse #1 said she then was instructed by the 911 dispatcher to administer Glucagon. Nurse #1 said she was unable to unlock the medication room door, which was where the Emergency Kit for that unit was located, and ran upstairs to another unit to get the Glucagon from their kit. Nurse #1 said the nurse on the other unit handed her Glucagon and an EpiPen, and she went back to Resident #2's room. Nurse #1 said she opened and read the instructions for the Glucagon, but when she administered the injection, she reached for, opened, and administered the EpiPen, by mistake. Nurse #1 said she was unaware that she had made the medication error until the following day, when the Administrator called her.During an interview on 09/02/25 at 01:52 P.M., The Director of Nurses (DON) said Nurse #1 should have ensured she administered the correct medication but did not.On 09/02/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 08/09/25, which addressed the area(s) of concern as evidenced by:A. 08/08/25, Resident #2 was readmitted to the Facility and had no ill effects as a result of the medication error that occurred on 08/07/25.B. 08/08/25, The ADON conducted a medication administration skills observation with Nurse #1.C. 08/08/25, The Ad-Hoc Quality Assurance Performance Improvement Action Plan indicated the Facility Leadership developed a plan to correct the deficient practice and ensure that residents were free from significant medication errors.D. 08/08/25, The DON and ADON educated all licensed staff on medication administration best practices, with focus on the Emergency Supply Kit review.E. 08/08/25, The DON and ADON began random medication pass observations with licensed staff.F. The DON and/or ADON will conduct ongoing weekly medication pass observations for four weeks.G. Results of the weekly medication pass observations will be reviewed at QAPI by the DON and/or ADON.H. The DON and/or ADON will continue to conduct annual and PRN medication competencies for all licensed staff.I. The DON/designee are responsible for overall compliance.