| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225210 | A. Building<br>B. Wing | 05/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Terrace Rehabilitation and Healthcare Ctr | 1675 North Main Street<br>Lancaster, MA 01523 |

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 - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that residents are free from significant medication errors.<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 02/25/25, Nurse #1 administered another resident's blood pressure medication to him/her in error. Resident #1 later experienced a change in condition, was lethargic, and his/her blood pressure was low, for which he/she required treatment and increased monitoring by nursing until his/her blood pressure stabilized.<br><br>Findings include:<br><br>The Facility Policy, titled Adverse Consequences and Medication Errors, dated as revised 02/2023, indicated medication errors were defined as the preparation or administration of drugs or biologicals which was not in accordance with physician's orders, and included administration of the wrong medication, and administration to the wrong resident. The Policy also indicated that a significant medication error was defined as one in which the resident required treatment with a prescription medication.<br><br>The Facility Policy, titled Administering Medications, dated as revised 04/2019, indicated:<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>-The nurse administering medications would check the medication label three times to verify the right resident, right medication, right dosage, and right route of administration before giving the medication.<br><br>According to MayoClinic.org, low blood pressure is a blood pressure reading lower than 90 millimeters of mercury (mm Hg) for the top number or 60 mm Hg for the bottom number, and extreme low blood pressure can lead to a condition called shock, which can be life threatening.<br><br>Review of the Facility's Incident Report Form, dated 03/03/25, indicated that on 02/25/25, at 03:00 P.M., nursing staff noticed that Resident #1 was lethargic, had difficulty standing while transferring, and his/her blood pressure was 84/46 mm Hg (hypotensive). The Incident Report indicated Resident #1's spouse was present, and said he/she thought Resident #1 might have been given his/her roommate's (Resident #2's) medication, in error. The Incident Report indicated that it was determined that Nurse #1 had administered Resident #2's scheduled 1:00 P.M., Hydralazine (lowers blood pressure) 30 milligrams (mg) to Resident #1, in error. On 02/25/25, Resident #1 and Resident #2 were roommates.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Resident #1 was admitted to the Facility in February 2025, diagnoses included Left femur fracture, dementia, acute diastolic heart failure (left heart ventricle is stiff and does not relax properly between heartbeats. Diastolic heart failure can lead to decreased blood flow) and Atrial fibrillation (irregular heart rhythm).<br><br>Review of Resident #1's Medication Administration Record (MAR), dated 02/25/25, indicated he/she did not have a physician's order for Hydralazine.<br><br>Resident #2 was admitted to the Facility in January 2025, diagnoses included hypertension.<br><br>Review of Resident #2's MAR, dated 02/25/25 indicated he/she had an order for Hydralazine Hydrochloride, 10 milligrams (mg) tablet, administer three tablets (30 mg) by mouth, four times daily.<br><br>Review of Resident #1's Blood Pressure Summary Report, dated 12/12/25 through 12/24/25 indicated that during this time period, his/her lowest measured blood pressure was 104/51 mm Hg.<br><br>Review of Resident #1's Nurse Progress Note, dated 02/25/25, timed 05:28 P.M., indicated he/she received Hydralazine 30 mg (in error), his/her Blood Pressure was low, the physician was notified, nursing placed him/her in the Trendelenburg (feet elevated) position, intravenous (IV, anything that is administered into vein) fluids were initiated, and nursing initiated increased monitoring of his/her Blood Pressure.<br><br>During a telephone interview on 05/05/25 at 10:28 A.M., Nurse #1 said he did not work on the East Wing very often, and was not familiar with the unit Resident #1 and Resident #2 lived on. Nurse #1 said that on 02/25/25 at 01:30 P.M., he prepared Resident #2's scheduled Hydralazine dose, and was about to administer it, when a staff member interrupted him because another resident (Resident #3) needed assistance.<br><br>Nurse #1 said he placed the medication cup with Resident #2's Hydralazine in the top drawer of the medication cart, locked it, and went to attended to Resident #3. Nurse #1 said when he returned to the medication cart at 02:00 P.M., he took the Hydralazine out from the medication cart drawer, and looked at the computer screen to see which resident the Hydralazine was intended for. Nurse #1 said he must have clicked (signed off in the electronic MAR) that he had completed Resident #2's medication pass, and therefore Resident #1's profile was on the screen. Nurse #1 said he did not review the medications against the MAR at that time, and went into the room, saw Resident #1 and administered the Hydralazine (that was ordered for Resident #2) to him/her, in error.<br><br>During an interview on 05/05/25 at 11:40 A.M., Certified Nurse Aide (CNA) #1 said she was familiar with Resident #1, that he/she usually transferred easily with one staff assist, however on 02/25/25 at 03:00 P.M., he/she was drowsy and had a hard time standing, so she was not able to transfer him/her alone. CNA #1 said Resident #1's spouse was visiting and asked her if Resident #1 had been started on a new blood pressure medication, and told her that Nurse #1 had given Resident #1 something for his/her blood pressure earlier that afternoon. CNA #1 said she immediately notified Unit Manager #1 that something was wrong.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | During an interview on 05/05/25 at 08:10 A.M., Unit Manager #1 said that on 02/25/25 at 03:00 P.M., CNA #1 notified him that Resident #1 was not feeling well. Unit Manager #1 said he went to assess Resident #1, and his/her spouse said that earlier, Nurse #1 had given him/her three small white pills that he/she had not gotten before, and suspected they were someone else's medication. Unit Manager #1 said Resident #1 was lethargic, weak, and his/her blood pressure was low. Unit Manager #1 said he cross checked Resident #1's and Resident #2's MARs and saw that Resident #2 was scheduled to receive Hydralazine, three 10 mg tablets, and that they were small white tablets.<br><br>Unit Manager #1 said he asked Nurse #1 if he had accidentally administered Resident #2's Hydralazine to Resident #1, and said Nurse #1 then realized that he had made a medication error.<br><br>During an interview on 05/05/25 at 10:52 A.M., the Director of Nurses (DON) said that on 02/25/25 at 03:00 P.M., Unit Manager #1 told her that Nurse #1 had administered Resident #2's Hydralazine to Resident #1 in error. The DON said she notified the physician of the medication error, and obtained physician's orders for Resident #1 to receive Normal Saline, 1 Liter via IV at 100 mL/hour, and increased monitoring of his/her blood pressure.<br><br>Review of Resident #1's MAR indicated nursing monitored his/her blood pressure as ordered, and by 04:00 P.M., his/her blood pressure measured 130/68 mm Hg and had stabilized.<br><br>Review of Resident #1's Nurse Progress Note, dated 02/25/25, timed 11:55 P.M., indicated he/she had self-removed his/her IV line after infusion of 600 mL of Normal Saline, his/her physician was notified, and no further orders were obtained. The Progress Note indicated Resident #1's Blood Pressure was stable at that time and measured 102/59 mm Hg.<br><br>The DON said Nurse #1 should have compared the medications he prepared against the MAR and correctly identified the resident that the medications were prescribed for before he administered the medication, but had not.<br><br>On 05/05/25, the Facility was found to be in Past Non-Compliance and provided the Surveyor<br><br>with a plan of correction which addressed the area of concern as evidenced by:<br><br>A) 02/25/25, Resident #1's physician was notified of the medication error, new orders were obtained, and he/she recovered from the hypotension caused by the accidental overdose of Hydralazine<br><br>B) 02/25/25, 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.<br><br>C) 02/26/25, The DON/designee conducted an initial audit to determine if residents were being properly identified by nursing prior to medication administration. Audits will continue weekly until 04/04/25, then bi-weekly.<br><br>D) 02/26/25, The DON/designee conducted an audit of resident photos and updated them as needed to most accurately reflect the residents' appearances.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | E) 02/27/25, The DON, ADON, and SDC educated all Facility staff that nurses should not be disturbed during medication preparation and administration, unless the interruption is critical.<br><br>F) 02/27/25, The DON/designee provided signs to be posted on each medication cart that indicate not to disturb nurses during medication administration.<br><br>G) 03/03/25, The DON, ADON, and SDC educated all Licensed staff on medication administration best practices, with focus on identification of residents prior to medication administration and avoiding common medication errors.<br><br>H) The Facility will monitor compliance at monthly and quarterly Quality Assurance Meetings.<br><br>I) The Director of Nurses and/or designee are responsible for ongoing compliance. |