STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225225	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Rehabilitation & Skilled Care Center	184 Lincoln Street North Easton, MA 02356

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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews for one of five sampled residents (Resident #1), the Facility failed to ensure he/she was free from a significant medication error, when upon readmission Resident #1's medications were not reconciled accurately, resulting in multiple medication errors related to missed doses. Findings include: Review of the Facility Policy titled Medication Error Reporting, dated as last revised 04/2015, indicated that a medication error is a preventable event that may cause or lead to inappropriate medication use. Review of the facility Policy titled, Medication Reconciliation, dated as last revised 08/2022, indicated that the Facility reconciles medications frequently throughout a resident's stay to ensure that the resident is free from any significant medication errors. The Policy further indicated that Medication Reconciliation refers to the process of verifying that the current medication list matches the physician's orders for the purpose of providing the correct medications to the resident at all points throughout his/her stay. Resident #1 was admitted to the Facility in February 2025, diagnoses include but not limited to a Subarachnoid Hemorrhage (SAH, bleeding between the brain and the tissue covering the brain), bilateral femoral Deep Vein Thromboses (DVT, blood clot in the vein), and he/she had an Inferior Vena Cava (IVC, small device that can stop blood clots) filter in place. Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated to administer the following; -Apixaban (Eliquis, an anticoagulant) five (5) milligrams (mg) by mouth twice daily, for 30 days (with a stop date of 3/08/25), -Buspirone (Buspar, antianxiolytic) 5 mg by mouth daily three times a day, and -Gabapentin (anticonvulsant) 300 mg by mouth, three times a day, for seven days. Further review of Resident #1's medical record indicated he/she required transfer to an acute care setting on 2/21/25 and his/her Hospital Discharge summary, dated [DATE], indicated to administer the following; (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Eliquis 5 mg by mouth twice daily; (no stop date indicated), -Buspar 5 mg by mouth daily; and -Gabapentin 300 mg by mouth three times a day (no time limit indicated). Review of Resident #1's Medical Record, indicated that there was no documentation to support a Medication Reconciliation Form had been completed by nursing at the time of his/her readmission. Review of Resident #1's Physician's Orders, dated 02/23/25, indicated that there was not documentation to support that nursing clarified, reconciled or obtained new orders regarding these medications from his/her Physician upon readmission. There was no documentation to support - if the Eliquis was it to be administered for 30 days and discontinued on 3/08/25, or continued, - if the Buspar was to be administered three times a day (per previous orders) or once a day (per new Hospital DC summary). Review of Resident #1's MAR, dated 02/23/24 through 05/18/25 indicated the Eliquis and Bursar were still being administered as ordered (per the original admission physician's orders) prior to his/her acute transfer to the hospital on [DATE]. -Eliquis 5 mg was stopped on 03/08/25, and there were no additional new orders or clarification for Eliquis obtained until 05/11/25 when the Physician provided new order for Eliquis 5 mg twice a day, and therefore Resident #1 was not administered Eliquis for 48 days; Review of Resident #1's Nurse Progress Note, dated 05/11/25, indicated he/she notified the nurse that he/she was no longer receiving his/her Eliquis and did not know why. Review of Resident #1's Physician's Order, dated 05/11/25, indicated to administer Eliquis 5 mg by mouth twice daily. -Buspar 5 mg was administered to Resident #1 three times a day from 2/23/25 until 03/11/25, when the dose is increased to 10 mg three times a day. -Gabapentin 300 mg by mouth three times daily, was not not administered after readmission, was not on the MAR and he/she therefore went 83 days without the medication. During an interview on 06/04/25 at 10:28 A.M., Nurse #2 said that when a new admission comes in, the Unit Manager enters the medications into Point Click Care (PCC, electronic medication record) and the admitting nurse will double check the medications before getting the orders approved by the Physician. Nurse #2 said that medication reconciliation must be completed upon admission and readmission. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/25 at 10:48 A.M., the Unit Manager said that she was unaware that Resident #1's medications were not reconciled upon readmission. The Unit Manager said that medication reconciliation is very important, should always be completed by two nurses for accuracy and then be double checked by nursing management the next day for any errors. During an interview on 06/04/25 at 10:08 A.M., the Assistant Director of Nurses (ADON), said that he was unaware that Resident #1's medications had not been reconciled upon readmission. The ADON said that the Facility utilizes a Medication Reconciliation Form and is to be completed by two nurses each time a resident is admitted or readmitted to the Facility. During an interview on 06/04/25 at 9:23 A.M., the Director of Nurses (DON) said that she was unable to locate Resident #1's Medication Reconciliation Form for his/her readmission. The DON said that the Facility's expectation is that once a Resident is discharged to the Hospital, all medications and treatments must be discontinued and then upon readmission two nurses are to reconcile all medications and treatments from the Discharge Summary provided by the Hospital, with physician's orders obtained.