STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225268	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Newton	2101 Washington Street Newton, MA 02462

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 0756 Level of Harm - Actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - 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 #1), whose physician's orders included the administration of a medication with a black box warning, the facility failed to ensure the dispensing Pharmacist and the Pharmacy Consultant identified and reported a medication that was prescribed and administered at an excessive frequency, which resulted in Resident #1 experiencing an overall decline in condition, requiring transfer and admission to the hospital.Findings include:Review of the facility's policy, titled Pharmacy Services Overview, with a revision date of 04/2019, included the following:-Pharmaceutical services consist of:*the processes of receiving and interpreting prescriber's orders; receiving, reconciling, and dispensing.all medications.*the process of identifying, evaluating and addressing medication-related issues including the prevention and reporting of medication errors.-The facility shall contract with a licensed consultant pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements.Review of the website, accessdata.fda.gov, approved by the U.S. Food and Drug Administration (FDA) indicated the following:-The recommended frequency to administer Methotrexate for both the treatment of psoriasis and rheumatoid arthritis, is weekly.-Methotrexate has a black box warning (the most serious warning the FDA uses to alert consumers and providers of possible risks associated with the use of this medication).-Taking more Methotrexate than prescribed or taking Methotrexate more often than prescribed, can lead to severe side effects and cause death.-If too much Methotrexate is consumed, immediate medical care is required to help reduce side effects that could be severe and could cause death. Resident #1 was admitted to the facility in July 2025, diagnoses included Antiphospholipid Syndrome (an autoimmune, hypercoagulable state which can lead to blood clots in both arteries and veins, and other symptoms like low platelets) and CREST syndrome (also known as the limited cutaneous (skin) form of systemic sclerosis which causes the body to destroy healthy tissue).Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she was to receive Methotrexate 2.5 milligram (mg) tablets, 10 tablets by mouth [once] every 7 days (5 tablets in the morning and 5 tablets in the evening, for a total dose of 25 mg). Review of Resident #1's Physician's Orders for the month of July 2025, indicated there was order to administer Methotrexate 2.5 mg, give 5 tablets by mouth two times a day (9:00 A.M. and 5:00 P.M.) for RA (Rheumatoid Arthritis). The order also included the following information: hazardous drug, wear gloves and wash hands thoroughly after handling. Pregnant women should avoid contact with this medication. During an interview on 09/03/25 at 1:04 P.M., Nurse #1 said he reconciled Resident #1's medications upon his/her admission to the facility and entered the medications in his/her Electronic Medical Record (EMR). Nurse #1 said that Physician #1 had previously reviewed and approved Resident #1's medications which were listed on his/her Hospital Discharge Summary.Nurse #1 said he made an error when he entered the medication in Resident #1's EMR and instead of entering the Methotrexate to be given in the morning and at night once per week, he entered for it to be given in the morning and at night every day. Review of Resident #1's Medication Administration Record (MAR) for the month of July 2025 indicated for the Methotrexate he/she received 25 mg total on the following:-07/23/25 to 07/25/25, 25 mg daily-07/26/25, 12.5 mg daily-07/27/25 to 07/30/25, 25 mg daily-07/31/25, 12.5 mg dailyDuring a telephone interview on 09/04/25 at 12:16 P.M., the Pharmacy Director said that 120 tablets of Methotrexate were dispensed for Resident #1 upon receiving his/her admission orders from the Facility.The Pharmacy Director said that Resident #1's Methotrexate order was flagged for a Drug Utilization Review (DUR) and the Pharmacist who dispensed the medication, overrode the DUR alert. The Pharmacy Director said the DUR alert was triggered to alert the dispensing Pharmacist to contact the Facility to verify the dose and frequency of the Methotrexate order.The Pharmacy Director said, had the contact with the Facility taken place and the medication verified, this error would likely have been discovered before the medication was sent out to the Facility.Review of Resident #1's Interim Medication Regimen Review, dated 07/24/25, indicated a Pharmacy Consultant reviewed Resident #1's physician's orders and did not identify or report the order for Resident #1 to receive Methotrexate 25 milligrams (total dose) by mouth daily.During a telephone interview on 09/04/25 at 12:16 P.M., the Pharmacy Director said the Pharmacy Consultant reviewed Resident #1's medications on 07/24/25 and the excessive dosing in the Methotrexate order should have been identified and reported as inappropriate.Review of Resident #1's Nursing Progress Note, dated 07/31/25, indicated he/she had acute

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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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 - 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 #1), whose physician's orders included administration of a potentially toxic medication (oral chemotherapy agent used to treat rheumatoid arthritis) the facility failed to ensure he/she was free from a significant medication error, when upon admission, the medication was inaccurately reconciled from his/her Hospital Discharge Summary by nursing and he/she was administered the medication for consecutive days in error. Resident #1 experienced an overall decline in condition, was transferred and admitted to the Hospital, and was treated for toxic levels of the medication. Findings include:Review of the Facility's policy, titled Adverse Consequences and Medication Errors, with a revision date of 06/2025, indicated the following:-A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services.-A significant medication-related error is defined as requiring medication discontinuation; requiring hospitalization; requiring treatment with a prescription medication; life threatening and/or resulting in death.-Evaluate the resident for possible medication-related adverse consequences when the resident has a significant change in clinical condition/status including unexplained decline in function, cognition or behavior; or worsening of an existing problem or condition.Review of the Facility's policy, titled Medication Reconciliation, with a revision date of 12/2014, indicated the following:-The Center will accurately reconcile medications of newly admitted residents to contribute to the creation of an accurate medication list. -Prescribing errors may occur when a patient is admitted to the hospital or transferred across the continuum of care to the skilled nursing center; these errors may result in adverse drug events.-Medication reconciliation is a formal process of obtaining a complete and accurate list of each patient's current medication (including name, dosage, frequency, and route) and comparing the incoming admission, transfer and or discharge medication orders to that list. Discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders.Review of the website, accessdata.fda.gov, approved by the U.S. Food and Drug Administration (FDA) indicated the following:-The recommended frequency to administer Methotrexate for both the treatment of psoriasis and rheumatoid arthritis, is weekly.-Methotrexate has a black box warning (the most serious warning the FDA uses to alert consumers and providers of possible risks associated with the use of this medication).-Taking more Methotrexate than prescribed or taking Methotrexate more often than prescribed, can lead to severe side effects and cause death.-If too much Methotrexate is consumed, immediate medical care is required to help reduce side effects that could be severe and could cause death.Resident #1 was admitted to the facility in July 2025, diagnoses included Antiphospholipid Syndrome (an autoimmune, hypercoagulable state which can lead to blood clots in both arteries and veins, and other symptoms like low platelets) and CREST syndrome (also known as the limited cutaneous (skin) form of systemic sclerosis which causes the body to destroy healthy tissue).Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she was to receive Methotrexate 2.5 milligram (mg) tablets, take 10 tablets [25 mg] by mouth [once] every 7 days (5 tablets [12.5 mg] in the morning and 5 tablets in the evening).Review of Resident #1's Medication Administration Record (MAR) for the month of July 2025, indicated he/she a physician's order to administer Methotrexate 2.5 mg, give 5 tablets by mouth two times a day (9:00 A.M. and 5:00 P.M.) for RA (Rheumatoid Arthritis). The order also included the following warning: hazardous drug, wear gloves and wash hands thoroughly after handling. Pregnant women should avoid contact with this medication. Review of Resident #1's Medication Administration Record (MAR) for the month of July 2025 indicated for the Methotrexate he/she received 25 mg total on the following:-07/23/25 to 07/25/25, 25 mg daily-07/26/25, 12.5 mg daily-07/27/25 to 07/30/25, 25 mg daily-07/31/25, 12.5 mg dailyDuring an interview on 09/03/25 at 1:04 P.M., Nurse #1 said he entered the physician's orders in Resident #1's Electronic Medical Record (EMR) upon his/her admission to the facility. Nurse #1 said that Physician #1 had previously reviewed and approved Resident #1's medications which were listed on his/her Hospital Discharge Summary.Nurse #1 said he made an error when he entered the medication in Resident #1's EMR and instead of entering the Methotrexate to be given in the morning and at night once per week, he entered for it to be given in the morning and at night, every day.Nurse #1 said he was unfamiliar with the intended use and usual dosing for Methotrexate prior to this incident.During a telephone interview on 09/04/25 at 9:02 A.M., Physician #1 said he was in the facility when Resident #1 was

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the facility failed to ensure his/her medical record was complete and accurate when 1) the Physician signed a medication order in error and 2) the Nurse Practitioner documented that all of Resident #1's medications were reviewed at each visit.Findings include:Review of the facility's policy, titled Charting and Documentation, with a revision date of 07/2017, indicated the following:-Documentation in the medical record will be objective, complete, and accurate.-Electronic entries that are auto-filled, or auto-prompts must be reviewed and updated when more current information is available or required; or accepted as it is after review.Review of the facility's policy, titled Medication and Treatment Orders, with a revision date of 07/2016, indicated the following:-Orders for medications and treatments will be consistent with principles of safe and effective order writing.-The signing of orders shall be by signature or a personal computer key.Resident #1 was admitted to the facility in July 2025, diagnoses included Antiphospholipid Syndrome (an autoimmune, hypercoagulable state which can lead to blood clots in both arteries and veins, and other symptoms like low platelets) and CREST syndrome (also known as the limited cutaneous (skin) form of systemic sclerosis which causes the body to destroy healthy tissue).Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she was to receive Methotrexate 2.5 milligram (mg) tablets, take 10 tablets by mouth every 7 days (5 tablets in the morning and 5 tablets in the evening).1) Review of Resident #1's Order Audit Report for his/her Methotrexate medication order indicated the following:-On 07/22/25 Nurse #1 entered a medication order for Methotrexate Tablet 2.5 milligrams -Give 5 tablets by mouth two times a day for R/A (Rheumatoid Arthritis).-The Methotrexate medication order was electronically signed by Physician #1 on 07/28/25.During a telephone interview on 09/04/25 at 9:02 A.M., Physician #1 said he was in the facility when Resident #1 was admitted . Physician #1 said he had reviewed his/her Hospital Discharge Summary and that all the medications listed on the Summary were to be continued at the facility. Physician #1 said he was very familiar with Methotrexate and that it was administered weekly.Physician #1 said that orders are sent to him electronically and often are received in bulk with 150 to 200 orders received at a time. Physician #1 said he had no reason to believe there had been a transcription error when nursing initially entered the orders for Resident #1 and therefore, he signed his/her order for Methotrexate to be administered twice daily instead of once weekly.2) Review of Resident #1's Nursing Progress Notes, indicated Nurse Practitioner (NP) #1 visited Resident #1 at the facility on 07/23/25 and 07/28/25.Review of Resident #1's NP Progress Notes indicated that on 07/23/25 and 07/28/25, NP #1 documented that Resident #1's Methotrexate order was as follows:-Methotrexate 2.5 milligrams- take 5 [tablets] by mouth everyday two times per day.During a telephone interview on 09/04/25 at 8:35 A.M., Nurse Practitioner #1 said that although he listed all of Resident #1's medications in his Progress Notes, he reviewed only the medications that were pertinent to his visits. NP #1 said that Methotrexate was managed by specialists, and he was not familiar enough with the recommended administration frequency to have questioned the directions as they were listed on Resident #1's physician's orders.During a telephone interview on 09/04/25 at 9:55 A.M., the Medical Director said he expected the providers to catch mistakes such as this Methotrexate medication order and that all entries made into the medical record must be right.During a telephone interview on 09/09/25 at 12:52 P.M., the Director of Nurses (DON) said he expected all medical record entries to be complete and accurate.