STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 Level of Harm - Minimal harm or potential for actual harm 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. Based on records reviewed and interviews, for one of four sampled residents (Resident #1), the Facility failed to ensure nursing staff promptly notified his/her medical provider and health care proxy of a significant medication error.Findings include:The Facility Policy, titled, MD Notification, dated 02/2022, indicated nursing staff would notify the resident's physician of any change in the resident's condition, treatment, and/or medication issues.The Facility policy, titled Medication Error, dated as revised 07/2021, indicated:-Examples of medication errors included but were not limited to wrong medication, wrong dose, and wrong resident.-When a medication error was identified it would be reported to the resident's physician and representative.Resident #1 was admitted to the Facility in January 2025 with diagnoses that included Parkinson's Disease, diabetes, epilepsy, dementia, and atrial fibrillation.Review of Resident #1's Invocation of Health Care Proxy/Durable Power of Attorney for Health Care Form, dated 10/12/23, indicated Resident #1's Health Care Proxy was invoked.Review of Resident #1's Medication Administration Record (MAR) for 03/2026 indicated that on 03/29/26 he/she received the following morning medications:-Aspirin (blood thinner) 81 milligrams (mg) capsule by mouth, daily.-Clopidogrel (antiplatelet) 75mg tablet by mouth, daily.-Famotidine (prevents heartburn) 10mg tablet by mouth, daily.-Furosemide (diuretic) 20mg tablet QD-Isosorbide Mononitrate (improves blood flow to the heart) ER 30mg 3 tablets by mouth, daily.-Magnesium Oxide (supplement) 400mg tablet by mouth, daily.-Nuplazid (antipsychotic) 34mg capsule by mouth, daily.-Trazodone HCL (antidepressant) 50mg by mouth in the morning.-Carvidopa-Levodopa (antiparkinsonian) 25-100mg tablet by mouth, twice daily.-Carvedilol (anthypertensive) 3.125mg tablet by mouth, twice daily.-Divaloprex (anti seizure) delayed release sprinkle 125mg capsule by mouth, twice daily.-Klonopin (benzodiazepine anxiolytic) 0.5mg tablet by mouth, twice daily.-Metformin HCL (antidiabetic) 500mg, 2 tabs by mouth, twice daily.-Suralfate (for duodenal ulcers) 1 GM tablet by mouth, twice daily.-Buspirone HCL (anxiolytic) 5mg tablet by mouth, three times daily.-Gabapentin (anti seizure)100mg capsule 2 caps by mouth, three times daily.Review of the Medication Error Report, dated 03/30/26, indicated that on 03/29/26, the Director of Nurses was notified that Nurse #1 had administered Resident #2's morning medications to Resident #1, in error. The Report further indicated that Nurse #1 failed to notify Resident #1's physician and activated Health Care Proxy of the medication error.Review of Resident #2's MAR, dated 03/29/26, indicated that his/her morning medications [that were administered to Resident #1 in error] included the following:-Amlodipine Besylate (lowers blood pressure) 5mg tablet by mouth, daily.-Magnesium (supplement) 400 mg tablet by mouth, daily.-Pantoprazole Sodium (for acid reflux) 20 mg by mouth, daily.-Propanolol HCL (lowers blood pressure) 120 mg by mouth, daily.-Proscar (treats enlarged prostate) 5 mg tablet by mouth, daily.-Ativan (benzodiazepine anxiolytic) 1 mg by mouth, twice daily.-Clozaril (antipsychotic) 200 mg tablet by mouth, daily.-Depakote (antiseizure) 500 mg delayed release tablet by mouth, twice daily.-Risperidone (antipsychotic) 3 mg by mouth, twice daily.During a telephone interview on 05/19/26 at 08:35 A.M., Nurse #1 said that on 03/29/26 at 08:00 A.M., he prepared Resident #2's morning medications and asked a staff member (unable to recall exact name) who Resident #2 was. Nurse #1 said the staff member pointed in the direction of a table where three of the same gender (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents were seated but did not specify who Resident #2 was. Nurse #1 said he did not ask the staff member to further clarify Resident #2's identity, but entered the Unit Dining Room, and asked for Resident #2 by name. Nurse #1 said Resident #1 responded that he was Resident #2, and so he administered Resident #2's medication to Resident #1 in error.Nurse #1 said he became aware of the medication error about an hour after he administered Resident #2's medication to Resident #1. Nurse #1 said he knew he was supposed to but said he did not notify Resident #1's physician or Health Care Proxy (HCP) because he felt panicked.During an interview on 05/18/25 at 2:35 P.M., Nurse #2 said that on 03/29/26 he was Resident #1's assigned nurse and had administered his/her scheduled medications to him/her that morning. Nurse #2 said that at 09:00 A.M., Resident #2 told him that Nurse #1 had given Resident #1 his/her medications. Nurse #2 said when he questioned Nurse #1, he said he had administered Resident #2's medications to Resident #1 in error.Nurse #2 said he called the Director of Nurses (DON) to alert her of the medication error, and said the DON told him to have Nurse #1 notify Resident #1's physician of the medication error. Nurse #2 said he knew Nurse #1 had not notified Resident #1's physician and said he also did not notify Resident #1's physician of the medication error.During an interview on 05/20/26 at 10:36 A.M., the Director of Nurses (DON) said that on 03/29/26 at 10:00 A.M., Nurse #2 notified her that Nurse #1 had administered Resident #2's medications to Resident #1 in error. The DON said she told Nurse #2 that Resident #1's physician needed to be notified of the error. The DON said she was not in the Facility on 03/29/26 and said she did not follow up with either nurse to ensure the physician and HCP had been notified of the medication error and said she did not know the physician had not been notified until the following morning.The DON said that either Nurse #1 or Nurse #2 should have notified Resident #1's physician of the medication error right away but had not.On 05/20/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 04/08/26, which addressed the area(s) of concern as evidenced by:A. 03/30/26, The Facility notified Resident #1's physician and HCP of the medication error.B. 03/30/26, The Facility Leadership conducted a Root Cause Analysis of the medication error and subsequent failure by nursing staff to notify the physician and HCP of the error.C. 03/30/26, an Ad Hoc QAPI Meeting was conducted, indicated to review the incident and develop a corrective action plan to prevent future failure to notify the physician and resident representative of medication errors.D. 03/30/26, the ADON re-educated licensed staff that the physician and HCP/resident representative must be notified of any resident change in condition.E. 03/30/26, the ADON re-educated licensed staff to the five rights of medication passes.F. 04/07/26, The DON/designee conducted medication administration observations with licensed staff.G. 04/01/26, The Facility Leadership updated the Facility Policy for Medication Errors to include that the reporting of medication errors would be non-punitive.H. The DON/designee will conduct medication pass observations weekly.I. The Unit Managers/designee will conduct medication administration audits weekly.J. The DON/designee will conduct medication error tracking reviews monthly.K. Audit findings will be reviewed during the monthly QAPI meetings to evaluate effectiveness of interventions and determine the need for continued monitoring or additional corrective action.L. The DON/designee are responsible for ongoing compliance.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of four sampled residents (Resident #3), who required a mechanical lift for all transfers, the Facility failed to ensure he/she was provided with equipment that was specifically designed for and appropriate for safe use during a mechanical lift transfer. On 04/18/26 nursing staff attempted to transfer Resident #3 via mechanical lift using a repositioning device, not a designated lift sling, Resident #3 slid out of the mechanical lift, fell to the floor, hit his/her head and received skin tears as a result of the fall. Resident #3 was transferred to the Hospital Emergency Department and was diagnosed with an Intraparenchymal hemorrhage (brain bleed) as a result of the fall.Findings include:The Facility Policy, titled Safe Transfer with the Mechanical Lift, dated 06/2022, indicated manufacturer recommendations would be followed when using the mechanical lift to transfer residents to ensure the safety of the resident.Review of the User Instruction Manual for the Hoyer HPL700 (Mechanical Lift) indicated do not use a sling unless it was recommended for use with the lift.Resident #3 was admitted to the Facility in March 2024, diagnoses included spinal stenosis, lumbar disk degeneration, dementia, and atrial fibrillation.Review of Resident #3's Activities of Daily Living Care Plan, dated initiated 04/20/24 and reviewed with his/her annual Minimum Data Set (MDS) assessment dated [DATE], indicated he/she required two staff members assistance using the mechanical lift device for all transfers.Review of the Facility's Investigation Summary, undated, indicated that on 04/18/26, Resident #3 was being transferred by two Certified Nurse Aides (CNAs) using the mechanical lift, and during the transfer he/she fell from the mechanical lift to the floor, struck his/her head, and was transferred to the Hospital Emergency Department.Review of Resident #3's Hospital Computed Tomography (CT) Scan, dated 04/19/26, indicated he/she had an 8-millimeter (mm) Intraparenchymal Hemorrhage (IPH) within the left occipital (back) lobe of the brain.During a telephone interview on 05/26/26 at 09:00 A.M., CNA #11 said that on 04/18/26 she was Resident #3's assigned CNA on the 07:00 A.M. to 3:00 P.M., shift, and said she could not find a lift sling large enough to transfer him/her in the mechanical lift. CNA #11 said she found what she later was told was a repositioning device in a box in the laundry room, which was a large flat pad that had loops around the outside, but did not have the longer straps that would crisscross between the residents' legs, like the straps on a normal mechanical lift sling. CNA #11 said the fact that the leg straps were missing should have been an indicator that this device was not a mechanical lift transfer sling, and she should not have used it. CNA #11 said CNA #12 helped her transfer Resident #3 from his/her bed to his/her wheelchair at 09:00 A.M., using the repositioning device without incident.During a telephone interview on 05/26/26 at 10:50 A.M., CNA #12 said that on 04/18/26 at 09:00 A.M., he assisted CNA #11 to transfer Resident #3 from his/her bed to his/her wheelchair. CNA #12 said CNA #11 had already placed a sling pad device under Resident #3, so he did not see what was used. CNA #12 said he knew that repositioning devices are not supposed to be used with the mechanical lift.CNA #11 and CNA #12 said they left the sling/pad they used to transfer Resident #3 into the wheelchair underneath him/her.During a telephone interview on 05/19/26 at 1:17 P.M., CNA #1 said that on 04/18/26 at 6:30 P.M., she and CNA #2 attempted to transfer Resident #3 from his/her wheelchair back to bed using the mechanical lift. CNA #1 said there was already a sling pad under Resident #3, that he/she was a large person, and therefore she could not really see what type of pad was under him/her in the wheelchair when she hooked the mechanical lift up to the loops that were attached to the pad.CNA #1 said when she raised Resident #3 up from the wheelchair she noticed that he/she was positioned leaning forward, saw that the pad was not a mechanical lift sling, said she told CNA #2 that it was not a mechanical lift sling, and that they had to lower Resident #3 back onto the wheelchair. CNA #1 said by the time she noticed, it was too late because Resident #3 slid out from the pad and fell onto the floor.CNA #1 said when she attached the pad to the mechanical (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	lift she had recognized that there were no leg straps that would have crisscross between Resident #3's legs, but said she had seen flat mechanical lift slings before, so that's what she thought it was, until Resident #3 was suspended in the lift and started to slip forward out of the pad.During a telephone interview on 05/21/26 at 10:45 A.M., CNA #2 said that on 04/18/26 at 6:30 P.M., she assisted CNA #1 with transferring Resident #3 from his/her wheelchair using the mechanical lift. CNA #2 said she hooked up one side of the lift sling/pad and said she noticed that the pad under Resident #3 seemed different than the usual mechanical lift slings they used. CNA #2 said the pad that was underneath Resident #3 did not have the long straps that crisscrossed between the residents' legs, so she assumed it was just a different type of mechanical lift sling/pad.During an interview on 05/20/26 at 11:28 A.M., Nurse #4 said that on 04/18/26 at 6:30 P.M., CNA #2 told her that Resident #3 had fallen out of the mechanical lift. Nurse #4 said Resident #3 had skin tears on his/her arms, and when she assessed him/her for injuries, Resident #3 said he/she had hit his/her head. Nurse #4 said Resident #3 was then transferred to the Hospital Emergency Department via 911 for evaluation.During an interview on 05/19/26 at 12:30 P.M., the Assistant Director of Nurses (ADON) said that during the facility's investigation of the incident, it was discovered that the pad used to transfer Resident #3 from his/her bed to his/her wheelchair on 04/18/26 was not a mechanical lift sling. The ADON said the pad was a repositioning pad, which is a large flat pad with handles around the edges used to reposition and slide a resident while they are in bed or from surface to surface, like when transferring from an ambulance gurney to a bed. The ADON said the Facility does not use these types of repositioning pads, and said they sometimes end up left behind by transport personnel when a resident is brought in from the Hospital. The ADON said repositioning pads are not intended or designed to be used as transfers slings with the mechanical lift.On 05/20/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 04/21/26, which addressed the area(s) of concern as evidenced by:A. 04/19/26, Resident #3 was readmitted to the Facility with new diagnosis of Intraparenchymal Hemorrhage (IPH). Nursing staff continued to monitor his/her neurological signs and treatments were applied to his/her skin tears.B. 04/19/26, The ADON re-educated nursing staff on the Facility's policy for mechanical lift transfers and observations for competencies were conducted.C. 04/19/26, The DON and ADON located and removed all repositioning pads from the Facility.D. 04/20/26, an Ad Hoc QAPI Meeting was conducted, Facility leadership met to develop a plan to ensure mechanical lift transfers would be completed safely with the appropriate designated equipment.E. 04/20/26, the Facility Leadership conducted a Root Cause Analysis which indicated it was determined that the primary cause of Resident #3's fall from the mechanical lift was due to staff's utilization of an improper device (repositioning pad) in the place of a transfer sling specifically designed to be used with the mechanical lift.F. 04/20/26, Residents whose care plans indicated they required use of the mechanical lift were assessed by Nursing Management to ensure they were assigned the correct size and appropriate type of mechanical lift sling.G. The DON or designee will continue to conduct random observations of mechanical lift transfers 10 times a month for three months.H. The Unit Managers will conduct Audits of mechanical lift sling once a month for three monthsI. The ADON or designee will ensure all newly hired nursing staff complete mechanical lift transfer competencies upon hire.J. Audit findings and compliance trends will be reviewed at monthly QAPI meetings to evaluate effectiveness of interventions and determine if there is a need for additional corrective actions.K. The DON and/or designee are responsible for ongoing and overall compliance.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on records reviewed and interviews, for one of four sampled residents (Resident #1), the Facility failed to ensure he/she was free from a significant medication error, when on 03/29/26, Resident #1 was administered his/her scheduled morning medications, and he/she was also administered Resident #2's medications in error.Findings include:The Facility Policy, titled Medication Error, dated as revised 07/2021, indicated:-It was the Facility policy to support the correct administration of medication to residents at all times.-Examples of medication errors included but were not limited to wrong medication, wrong dose, and wrong resident.Resident #1 was admitted to the Facility in January 2025 with diagnoses that included Parkinson's Disease, diabetes, epilepsy, dementia, and atrial fibrillation.Review of Resident #1's Medication Administration Record (MAR) for 03/2026 indicated that on the morning of 03/29/26 he/she was administered the following scheduled medications:-Aspirin (blood thinner) 81 milligrams (mg) capsule by mouth, daily.-Clopidogrel (antiplatelet) 75mg tablet by mouth, daily.-Famotidine (prevents heartburn) 10mg tablet by mouth, daily.-Furosemide (diuretic) 20mg tablet QD-Isosorbide Mononitrate (improves blood flow to the heart) ER 30mg 3 tablets by mouth, daily.-Magnesium Oxide (supplement) 400mg tablet by mouth, daily.-Nuplazid (antipsychotic) 34mg capsule by mouth, daily.-Trazodone HCL (antidepressant) 50mg by mouth in the morning.-Carvidopa-Levodopa (antiparkinsonian) 25-100mg tablet by mouth, twice daily.-Carvedilol (anthypertensive) 3.125mg tablet by mouth, twice daily.-Divaloprex (anti seizure) delayed release sprinkle 125mg capsule by mouth, twice daily.-Klonopin (benzodiazepine anxiolytic) 0.5mg tablet by mouth, twice daily.-Metformin HCL (antidiabetic) 500mg, 2 tabs by mouth, twice daily.-Suralfate (for duodenal ulcers) 1 GM tablet by mouth, twice daily.-Buspirone HCL (anxiolytic) 5mg tablet by mouth, three times daily.-Gabapentin (anti seizure)100mg capsule 2 caps by mouth, three times daily.Review of the Medication Error Report, dated 03/30/26, indicated that on 03/29/26, the Director of Nurses was notified that Nurse #1 had administered Resident #2's morning medications to Resident #1, in error. Review of Resident #2's MAR for 03/2026 indicated that on the morning of 03/29/26, he/she was scheduled to have the following medications administered:-Amlodipine Besylate (lowers blood pressure) 5mg tablet by mouth, daily.-Magnesium (supplement) 400 mg tablet by mouth, daily.-Pantoprazole Sodium (for acid reflux) 20 mg by mouth, daily.-Propanolol HCL (lowers blood pressure) 120 mg by mouth, daily.-Proscar (treats enlarged prostate) 5 mg tablet by mouth, daily.-Ativan (benzodiazepine anxiolytic) 1 mg by mouth, twice daily.-Clozaril (antipsychotic) 200 mg tablet by mouth, daily.-Depakote (antiseizure) 500 mg delayed release tablet by mouth, twice daily.-Risperidone (antipsychotic) 3 mg by mouth, twice daily.Review of the Medication Error Report, dated 03/30/26, indicated that on 03/29/26 [around 8:00 A.M.], Nurse #1 administered Resident #2's morning medications to Resident #1, in error.During a telephone interview on 05/19/26 at 08:35 A.M., Nurse #1 said that on 03/29/26 at 08:00 A.M., he prepared Resident #2's morning medications, and asked a staff member (unable to recall exact name) who Resident #2 was. Nurse #1 said the staff member pointed in the direction of a table where three of the same gender residents were seated but did not specify who Resident #2 was. Nurse #1 said he did not ask the staff member to further clarify Resident #2's identity, but entered the Unit Dining Room, and asked for Resident #2 by name.Nurse #1 said Resident #1 responded that he was Resident #2, and so he administered Resident #2's medication to Resident #1 in error. Nurse #1 said he became aware of the medication error about an hour after he administered Resident #2's medication to Resident #1.During an interview on 05/18/25 at 2:35 P.M., Nurse #2 said that on 03/29/26 he was Resident #1's assigned nurse and had administered his/her scheduled medications to him/her that morning. Nurse #2 said that at around 09:00 A.M., Resident #2 told him that Nurse #1 had given his/her medications to Resident #1. Nurse #2 said when he questioned Nurse #1 about the medications, that Nurse #1 told him he had administered Resident #2's medication to Resident #1, in error.During an interview on 05/20/26 at 10:36 A.M., the Director of Nurses (DON) said that on 03/29/26 at 10:00 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M., Nurse #2 notified her that Nurse #1 had administered Resident #2's medications to Resident #1 in error. The DON said Nurse #1 should have identified Resident #2 using another resident identifier before administering the medication but did not.On 05/20/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 04/08/26, which addressed the area(s) of concern as evidenced by:A. Resident #1 was monitored by nursing for signs and symptoms of adverse reaction to the medications, he/she remained at baseline that day. Resident #1 was transferred to the hospital the next day related to complications from a Urinary Tract Infection and returned the same day.B. Facility Medical Director reviewed the medications error, and nursing actions implemented related to monitoring.C. 03/30/26, The Facility notified Resident #1's physician of the medication error.D. 03/30/26, The Facility Leadership conducted a Root Cause Analysis of the medication error incident.E. 03/30/26, an Ad Hoc QAPI Meeting Minutes was conducted to review the incident and develop a corrective plan to prevent future medication errors.F. 03/30/26, the ADON re-educated licensed staff that the physician must be notified of any resident change in condition.G. 03/30/26, the ADON re-educated licensed staff to the five rights of medication passes.H. 04/07/26, The DON/designee conducted medication administration observations with licensed staff.I. 04/2026, The Facility Leadership updated the Facility Policy for Medication Errors to include that the reporting of medication errors would be non-punitive.J. The DON/designee will conduct random medication pass observations weekly.K. The Unit Managers/designee will conduct medication administration audits weekly.L. The DON/designee will conduct medication error tracking reviews monthly.M. Medication Audit findings will be reviewed during monthly QAPI meetings to evaluate effectiveness of interventions and determine the need for continued monitoring or additional corrective action.N. The DON/designee are responsible for ongoing compliance.