STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225335	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Greenfield	95 Laurel Street Greenfield, MA 01301

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. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #3), whose Physician's Orders included the administration of two different narcotic medications for pain, one was scheduled to be administered two times a day, the other medication could be administered every four hours as needed (PRN), the Facility failed to ensure the resident was free from significant medication errors, when on two separate occasions instead of being administered the PRN narcotic medication, Nurse #4 administered him/her the scheduled narcotic medication, placing Resident #1 at increased risk for adverse effects of a narcotic medication. Findings include: Review of the Facility's policy titled Oral Medication Administration, dated 04/2022, indicated the purpose of this procedure is to provide guidelines for the safe administration of oral medications. Steps in the procedure: -Place the Medication Administration Record (MAR) within easy viewing distance. -Select the medication from the unit dose drawer (medication cart). -Check the label on the medication and confirm the medication's name and dose with the MAR. -Check the medication dose. Re-check to confirm the proper dose. -For narcotics, check the narcotic record for the previous drug count and compare with the supply on hand. -Confirm the identity of the resident. -Allow the resident to swallow oral tablets or capsules at his/her comfortable pace. -Document medication administered on the MAR. Resident #3 was admitted to the Facility in April 2024, diagnosis include right hip osteoarthritis. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Medication Administration Record (MAR) for the month of July 2024 indicated his/her physician's orders for narcotic medications was as follows: -Oxycontin (opioid, narcotic)10 milligram (mg) extended-release (slowly released in the body over a period of time, usually 12 to 24 hours) tablet, give 10 mg by mouth two times a day for pain at 0800 (8:00 A.M.) and 1600 (4:00 P.M.). -Oxycodone (opioid, narcotic) 5 mg tablet, give 5 mg by mouth every four hours, as needed, for pain. -Oxycodone 5 mg tablet, give 10 mg [two tablets] by mouth every four hours, as needed, for pain. Review of Resident #3's Medication Variance Report, dated 07/05/24 and signed by Nurse #4, indicated that Resident #3 requested pain medication for pain level 8 out of 10 and that Resident #3 always asked for Oxycodone 10 mg [two 5 mg tablets] and this writer (Nurse #4) unintentionally administered the Oxycontin [two 10 mg tablets, total of 20 mg] instead of the Oxycodone to Resident #3. The Report indicated Resident #3 slept better and was easily aroused when it was time to wake up. Review of the Facility's Controlled Substance Log (book used by nursing to keep an accurate count of all narcotics and to record administration of narcotics) for Resident #3's Oxycontin, indicated that two Oxycontin 10 mg tablets were removed from the count on 07/05/24 at 2:30 A.M., by Nurse #4. Review of Resident #3's Medication Variance Report, dated 07/21/24 and signed by Nurse #4, indicated that the writer (Nurse #4) believed that at 2:00 A.M. after checking twice that she was giving him/her two tablets of the Oxycodone 5 mg, instead accidentally gave Resident #3 two [10 mg] tablets of Oxycontin [total of 20 mg], the error was discovered at change of shift during the narcotic count. The Report indicated Resident #3 stated he/she felt fine. Review of the Facility's Controlled Substance Log for Resident #3's Oxycontin, indicated that two Oxycontin 10 mg tablets for Resident #3 were removed from the count on 07/21/24 at 6:00 A.M., by Nurse #4. During a telephone interview on 12/05/24 at 10:46 A.M., Nurse #4 said she worked the night shift (11:00 P.M. - 7:00 A.M.) at the time of Resident #3's medication incidents [07/05/24 and 07/21/24]. Nurse #4 said that Resident #3's narcotic medications were in blister pack cards next to each other in the narcotic box. Nurse #4 said she thought she had pulled the correct card of medication, but on both occasions she pulled Resident #3's Oxycontin instead of his/her Oxycodone. Nurse #4 said she gave him/her two Oxycontin 10 mg tablets [total 20mg] instead of two Oxycodone 5 mg tablets [total 10mg] both times. Nurse #4 said the medications were the same color which may have contributed to the errors. During an interview on 12/04/24 at 3:35 P.M., the Director of Nurses (DON) said she had been notified of both Resident #3's medication errors. The DON said she expected the nurses to administer the medications as ordered by the physician.

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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 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. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #3), whose Physician's orders included the administration of two different narcotic pain medications, one that was scheduled, the other was a PRN (as needed only), the Facility failed to ensure nursing maintained an accurate medical record when although Nursing documentation indicated Resident #3 was administered his/her PRN (as needed) pain medication, on two different occasions, he/she was actually administered his/her scheduled narcotic pain medication in error. Findings include: Review of the Facility's policy titled Charting and Documentation, dated 04/2022, indicated that medications administered shall be documented in the resident's medical record. Resident #3 was admitted to the Facility in April 2024, diagnosis include right hip osteoarthritis. Review of Resident #3's Medication Administration Record (MAR) for the month of July 2024 indicated the following: -Oxycontin (opioid, narcotic)10 milligram (mg) extended-release tablet, give 10 mg by mouth two times a day for pain at 0800 (8:00 A.M.) and 1600 (4:00 P.M.). -Oxycodone (opioid, narcotic) 5 mg tablet, give 5 mg by mouth every four hours, as needed, for pain. -Oxycodone 5 mg tablet, give 10 mg [two tablets] by mouth every four hours, as needed, for pain. Further review of the MAR indicated that on 07/05/24, Nurse #4 signed off that she administered the PRN narcotic, Oxycodone 5 mg by mouth as needed for pain, and on 07/21/24 Nurse #4 signed off that she administered the PRN narcotic Oxycodone 10 mg by mouth as needed for pain, despite having dispensed and administered his/her Oxycontin 10 mg two tablets (which was not a PRN medication), in error, on both occasions. Review of Resident #3's Medication Variance Report, dated 07/05/24 and signed by Nurse #4, indicated that Resident #3 requested pain medication for pain level 8 out of 10 and this writer (Nurse #4) unintentionally administered the Oxycontin instead of the Oxycodone to Resident #3. Review of the Facility's Controlled Substance Log (book used by nursing to keep an accurate count of all narcotics and to record administration of narcotics) for Resident #3 indicated that two Oxycontin 10 mg tablets for Resident #3 were removed from the count on 07/05/24 at 2:30 A.M., by Nurse #4. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Medication Variance Report, dated 07/21/24 and signed by Nurse #4, indicated that the writer (Nurse #4) accidentally gave Resident #3 two tablets of Oxycontin [instead of Oxycodone], the error was discovered at change of shift during the narcotic count. Review of the Facility's Controlled Substance Log for Resident #3 indicated that two Oxycontin 10 mg tablets for Resident #3 were removed from the count on 07/21/24 at 6:00 A.M., by Nurse #4. During a telephone interview on 12/05/24 at 10:46 A.M., Nurse #4 said she worked the night shift (11:00 P.M. - 7:00 A.M.) at the time of Resident #3's medication incidents (7/05/24 and 7/21/24). Nurse #4 said that Resident #3's narcotic medications were in blister pack cards next to each other in the narcotic box. Nurse #4 said she thought she had pulled the correct card, but on both occasions she pulled Resident #3's Oxycontin instead of his/her Oxycodone. Nurse #4 said the medications were the same color which may have contributed to the errors. During an interview on 12/04/24 at 3:35 P.M., the Director of Nurses (DON) said she had been notified of both Resident #3's medication errors. The DON said she expected the nurses to administer the medications as ordered by the physician and document medication administration accurately.