

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2025
NAME OF PROVIDER OR SUPPLIER  Royal Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  359 Jones Rd Falmouth, MA 02540	

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)
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183</b></p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had severe cognitive impairment and was unable to identify him/herself, the Facility failed to ensure he/she was free from a significant medication error, when on 03/13/25, Resident #1 was administered another resident's medications in error. Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation, he/she remained in the Hospital overnight for monitoring and treatment to stabilize his/her blood pressure, which included administration of intravenous fluids and medications.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled, Administering Medications, dated as revised October 2022, indicated the following:</p> <ul style="list-style-type: none"> <li>-only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so;</li> <li>-medications are administered in accordance with prescriber orders;</li> <li>-the individual administering medications verifies the resident's identity before giving the resident his/her medications;</li> <li>-the individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication;</li> <li>-medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nurses.</li> </ul> <p>Review of the Facility's Policy titled, Medication Error, dated March 2025, indicated the following:</p> <ul style="list-style-type: none"> <li>-it is the policy of the facility to ensure residents receive care and services safely in an environment free of significant medication errors;</li> <li>-the facility shall ensure medications will be administered according to physician's orders;</li> </ul> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-to prevent medication errors and ensure safe medication administration, nurses should verify the right medication, dose, route and time of administration, right resident and right documentation.</p> <p>Resident #1 was admitted to the Facility in April 2024, diagnoses included late onset Alzheimer's disease, dementia, anemia, hypertension, hyperlipidemia, anxiety disorder paroxysmal atrial fibrillation and osteoarthritis of right and left knees.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], indicated that he/she was severely cognitively impaired.</p> <p>Review of Resident #1's Medication Variance Report, dated 03/13/25, indicated that at 9:45 A.M. he/she was administered medications ordered for another resident (later identified as Resident #2, his/her roommate) in error, which included the following medications:</p> <ul style="list-style-type: none"> <li>-Celexa (antidepressant) 10 milligrams (mg);</li> <li>-Eliquis (anticoagulant) 5 mg;</li> <li>-Haldol (anti-psychotic) 5 mg ;</li> <li>-Isosorbide Extended Release (ER) (nitrate- dilates blood vessels) 30 mg ;</li> <li>-Protonix (proton pump inhibitor - reduces stomach acid) 40 mg;</li> <li>-Miralax (laxative) 17 grams;</li> <li>-Senna (treats constipation) 17.2 mg;</li> <li>-Digoxin 125 micrograms (cardiac glycoside - treats arrhythmias);</li> <li>-Labetalol (antihypertensive) 800 mg;</li> <li>-Trazadone (antidepressant) 25 mg;</li> <li>-Amlodipine (antihypertensive) 2.5 mg.</li> </ul> <p>Further review of Resident #1's Physician's Orders indicated he/she did not have physician's orders for any of these medications.</p> <p>Review of Resident #1's Medication Administration Record (MAR), dated 03/13/25 indicated he/she was scheduled to have the following medications administered to him/her between 09:00 A.M. and 10:00 A.M.:</p> <ul style="list-style-type: none"> <li>-Sertraline (antidepressant) 100 mg;</li> <li>-Metoprolol ER (beta blocker) 25 mg.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility's Internal Investigation Report, dated 03/13/25, indicated that Agency Nurse #1 administered Resident #2's morning medications to Resident #1 in error. The Report indicated that Resident #1 was transferred to the Hospital ED, where he/she required telemetry (continuous tracking of your hearts electrical activity) monitoring and returned to the Facility the following day.</p> <p>Review of Resident #2's Physician's Orders, dated March 2025, indicated that he/she had Physician's Orders for the following medications:</p> <ul style="list-style-type: none"> <li>-Celexa (antidepressant) 10 milligrams (mg);</li> <li>-Eliquis (anticoagulant) 5 mg;</li> <li>-Haldol (anti-psychotic) 5 mg ;</li> <li>-Isosorbide Extended Release (nitrate- dilates blood vessels) 30 mg ;</li> <li>-Protonix (proton pump inhibitor - reduces stomach acid) 40 mg;</li> <li>-Miralax (laxative) 17 grams;</li> <li>-Senna (treats constipation) 17.2 mg;</li> <li>-Digoxin 125 micrograms (mcg) (cardiac glycoside - treats arrhythmias);</li> <li>-Labetalol (antihypertensive) 800 mg;</li> <li>-Trazadone (antidepressant) 25 mg;</li> <li>-Amlodipine (antihypertensive) 2.5 mg.</li> </ul> <p>The Report further indicated that Agency Nurse #1 approached Resident #1 called him/her by name and administered morning medications. The Report indicated that while Agency Nurse #1 was leaving Resident #1's room, a Certified Nurse Aide (CNA) entered the room, approached Resident #1 and addressed him/her by name. The Report indicated that Agency Nurse #1 confirmed Resident #1's name with the CNA and immediately realized she had administered Resident #2's medication to Resident #1 in error.</p> <p>Review of Resident #1's Hospital Discharge Summary, dated 03/14/25, indicated that on 03/13/25, Resident #1 presented to the ED for an accidental overdose of his/her roommate's medications. The Summary indicated that Resident #1 was supposed to receive: Metoprolol and Sertraline in the morning and instead received the following medications in error: Celexa 10 mg, Eliquis 5 mg, Haldol 5 mg, Isosorbide ER 30 mg, Protonix 40 mg, Miralax, Senna, Digoxin 125 mcg, Labetalol 800 mg, Trazodone 25 mg and Amlodipine 2.5 mg. The Summary indicated that after the medication error, Resident #1's blood pressure was 85/42 (normal range 120/80) and that his/her normal blood pressure was 150/60. The Summary indicated that during Resident #1's hospital stay, he/she required telemetry monitoring, 1000 milliliters of normal saline intravenous fluids, Magnesium sulfate 2 grams intravenous fluid, and four doses of Potassium Chloride 10 Milliequivalent (mEq) intravenous fluids for electrolyte repletion.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Summary further indicated that nursing staff had difficulty getting Resident #1 to take activated charcoal (used to treat overdose), plan was to have an Naso Gastric (NG) tube ( a thin, soft tube made of rubber that is passed through the nose, down through the throat, and into the stomach) inserted, he/she was agitated and unable to tolerate the NG tube, and NG tube was removed.</p> <p>Review of Resident #1's Nurse Progress Note, written by Nurse #1, dated 03/13/25, indicated that during morning medication pass, he/she was administered incorrect medications, physician was notified and he/she was transferred to the hospital.</p> <p>Review of Nurse #1's Written Witness Statement, dated 03/13/25, indicated that she approached Resident #1 by name and administered medication to him/her. The Statement indicated that upon departing Resident #1's room, a CNA approached Resident #1 (calling him/her by another name), she immediately realized that she had made a medication error, notified the physician and Resident #1 was transferred to the hospital.</p> <p>During an interview on 04/15/25 at 2:37 P.M., Nurse #1 said that on 03/13/25, she was assigned to work the dementia unit and said it was the first time she had worked on that unit. Nurse #1 said that she prepared Resident #2's morning medications and went into his/her room to administer them. Nurse #1 said that there was only one resident in the room, the other bed linens were stripped from that bed, so she believed that there was only one resident living in the room at that time. Nurse #1 said that she approached Resident #1, who was in the room and addressed him/her using Resident #2's name, and that Resident #1 shook his/her head in an up and down motion like he/she was saying yes and then administered the medications to Resident #1. Nurse #1 said that a CNA entered the room and said good morning to Resident #1 by another name. Nurse #1 said that she asked the CNA what Resident #1's name was and the CNA told her Resident #1's name and that is when she realized she administered Resident #2's medications to Resident #1 in error.</p> <p>Nurse #1 said that she had not positively identified who Resident #1 was with another staff member, and said she did not look at Resident #2's or Resident #1's pictures on the MAR prior to administering medications to Resident #1. Nurse #1 said she was unaware that Resident #1 was unable to understand or recognize his/her own name, or that he/she responded to any name when addressed. Nurse #1 said that she did not follow the five rights of medication administration.</p> <p>During an interview on 04/08/25 at 1:31 P.M., the Unit Manager said that on 03/13/25, Nurse #1 notified her that she had made a medication error. The Unit Manager said that Nurse #1 was from an Agency and that it was the first time that Nurse #1 worked on the Dementia Unit. The Unit Manager said that Nurse #1 said that she called Resident #1 by (Resident #2's) name and said that Resident #1 shook his/her head nodding up and down, in a yes motion, and she administered medications to him/her. The Unit Manager said that Nurse #1 said that after she administered medications to Resident #1, a CNA entered the room and called Resident #1 by another name, and realized she had administered Resident #2's medications to Resident #1 in error. The Unit Manager said that Resident #1 had dementia and severe cognitive impairment and would not be able to understand if he/she was called by another name.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/08/25 at 1:47 P.M., the Assistant Director of Nurses (ADON) said she was made aware of Resident #1's medication error on 03/13/25 by the Unit Manager. The ADON said that it was Nurse #1's first time working on the Unit and said she did not verify Resident #1's identity with another staff member. The ADON said that it was her expectation that nurses follow the five rights of medication administration, and positively identify a resident before administering any medications. The ADON said that Resident #1 had dementia, with severe cognitive impairment and would not be able to understand if he/she was called by another name.</p> <p>During an interview on 04/08/25 at 2:05 P.M., the Director of Nurses (DON) said that it was her expectation that nurses follow the five rights of medication administration and positively identify each resident before administering medication to any resident. The DON said that Resident #1 had severe cognitive impairment and would not be able to understand if he/she was called by another name.</p> <p>On 04/08/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidenced by:</p> <p>A. On 03/13/25, Resident #1 was assessed by nursing and transferred to the Hospital ED for evaluation and treatment. Resident #1 returned to the facility the next day, and was monitored by nursing.</p> <p>B. On 03/13/25 Nurse #1 was educated by the Assistant Director of Nurses on the Facility's Policy and Procedure on Medication Administration.</p> <p>C. On 03/13/25, a Quality Assurance Performance Improvement (QAPI) Committee meeting was held regarding medication administration, reduction of medication errors, resident identification, name band implementation for residents unable to confirm their identity.</p> <p>D. On 03/13/25, all Licensed staff were educated by the Corporate Nurse on the Facility's Medication Administration Policy, Resident Identification and the Five Rights of Medication Administration.</p> <p>E. 03/24/25, Random Medication Administration Competencies were conducted by Director of Nurses with licensed nursing staff.</p> <p>F. 04/01/25, An Audit was completed by the Unit Managers of Residents who were unable to identify themselves and those Residents had an identification wristband placed on their wrist.</p> <p>G. The Director of Nurses / Assistant Director of Nurses will conduct random medication administration competencies/audits with nursing staff three times weekly for four weeks, then they will audit 10% of nursing staff monthly for three months or until substantial compliance is met.</p> <p>H. The results of the audits will be presented and reviewed at the monthly QAPI Committee meeting for three months or until compliance is achieved.</p> <p>I. The Director of Nursing and/or designee are responsible for overall compliance.</p>		