STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225532	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Village at Mattapan	405 River Street Mattapan, MA 02126

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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required 1) anticonvulsant medication for epilepsy (seizure disorder) and 2) an anticoagulant (blood thinner) for a newly diagnosed deep vein thrombosis (DVT, blood clot), the Facility failed to ensure he/she was free from a significant medication error, when upon re-admission to the facility, his/her medication orders were not accurately reconciled by nursing resulting multiple missed doses of both medications. Resident #1 was observed experiencing seizure activity, was transported to the Hospital Emergency Department for evaluation and was admitted for treatment.Findings include:Review of the Facility Policy titled Medication Reconciliation and Management, undated, indicated medication reconciliation reduces adverse medication events and assists the resident to get the most effect from their medication.The Policy indicates to review and document all medications the resident is taking and compare the list to the hospital discharge summary. Identify any potential medication adverse effects, significant drug interactions, duplication, and non-adherence with drug therapy and notify the physician with any medication discrepancies. Review of the Facility Policy titled Adverse Consequences and Medication Errors, undated, indicated a medication error is defined as the preparation or administration of drugs or biologics which is not in accordance with physician's orders, manufactures specifications, or accepted professional standards.The Policy indicated a medication error includes an omission, a drug that is ordered but not administered.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 04/22/26, indicated (per the Hospital Discharge Summary) Resident #1 was supposed to be administered an anticonvulsant (used to prevent seizures) medication as well as maintained on a tapered dose of an anticoagulant (blood thinner). The Report indicated Resident #1's anticonvulsant (Keppra) had not been transcribed into the Point Click Care (PCC, Facility's electronic record) system upon readmission leading to a significant medication error.The Report further indicated upon investigation, a second transcription error had been identified, and that Resident #1's anticoagulant (Eliquis) had been transcribed incorrectly.Resident #1 was admitted to the Facility in July 2025, diagnoses include epilepsy (seizure disorder), toxic encephalopathy, Cerebral Vascular Accident (CVA), and gastric ulcer with a gastrostomy (tube inserted into the stomach to provide nutrition) in place. 1) Review of Resident #1's Hospital Discharge (DC) Summary, dated 04/11/26, indicated that he/she was to receive the following;-Keppra 1,500 milligrams (mg) via gastrostomy tube twice daily (BID)Review of Resident #1's Physician's Orders, dated 04/11/26 through 04/20/26, indicated there was no documentation to support his/her orders for Keppra had been transcribed upon readmission.Review of Resident #1's Medication Administration Record (MAR), dated 04/11/26 through 04/20/26, indicated there was no documentation to support his/her Keppra had been administered for ten (10) days (for a total of 18 missed doses).Review of Resident #1's Nurse Progress note (written by Nurse #1), dated 04/20/26, indicated he/she was observed having a seizure for more than 30 minutes, non-stop. The Note indicated Resident #1 was transported to the Hospital Emergency Department (ED) for evaluation.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she presented with breakthrough seizures in the setting of not receiving his/her seizure medication (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 - Actual harm Residents Affected - Few	(Keppra) at the Facility. 2) Review of Resident #1's Hospital DC Summary, dated 04/11/26, indicated that he/she was to receive the following;-starting 4/11/26 - nursing to administer Eliquis ten (10) mg by mouth BID for four (4) days (through 4/15/26); -starting 4/16/26 - nursing was to administer Eliquis five (5) mg by mouth BID for 90 days, for a newly diagnosed right upper extremity deep vein thrombosis (DVT).Review of Resident #1's MAR, dated 04/11/26 through 04/15/26, indicated he/she was administered Eliquis 10 mg by mouth BID for 4 days, as ordered.Review of Resident #1's Pharmacy Medication Review, dated 04/13/26, indicated nursing staff should ensure Eliquis 5 mg by mouth BID physician's order is entered [into the electronic medical record, PCC] prior to the start date [4/16/26] to prevent a delay in care.However, further review of Physician's Orders, indicated there was no documentation to support his/her Eliquis 5 mg (starting 04/16/26) BID for 90 days had been transcribed upon Resident #1's readmission. Review of Resident #1's MAR dated 04/16/26 through 04/20/26, indicated there was no documentation to support his/her Eliquis 5 mg by mouth BID had been administered for 5 days (for a total of nine (9) missed doses).During an interview on 05/13/26 at 4:32 P.M., Nurse #1 said on 04/11/26, he was Resident #1's nurse and was responsible for his/her medication reconciliation upon his/her readmission. Nurse #1 said he was having difficulty entering Resident #1's medications into PCC and that he forgot to go back to complete the transcription of his/her Keppra ordersNurse #1 said Resident #1's Keppra was never transcribed, ordered or administered despite being a physician's order on his/her Hospital DC summary and only one of the Eliquis orders had been entered into PCC.Nurse #1 said he did not reconcile Resident #1's medications with another nurse and was not aware errors were made during reconciliation until the Director of Nurses (DON) made him aware of the significant medication errors. During an interview on 05/13/26 at 2:37 P.M., the Nursing Supervisor said that she was not aware of the significant transcription medication errors made upon Resident #1's readmission until the Hospital called to inform the Facility of their findings.The Nursing Supervisor said Resident #1's Keppra was not transcribed onto his/her MAR upon his/her readmission and only a portion of his/her Eliquis medication order had been transcribed leading to the significant medication errors.The Supervisor said there had been a paper Medication Reconciliation Form that was being used prior to the initiation of PCC (EMR system, about four years ago) but since the start of PCC, those paper forms were no longer being utilized to reconcile medications. During an interview on 05/13/26 at 3:40 P.M., the Director of Nurses (DON) said she was unaware of Resident #1's significant medication error until the Hospital called to inform her that his/her Keppra was missing from his/her facility medication list [sent with him/her by the facility at time of transfer to the Hospital].The DON said that she reviewed the original Hospital Discharge Summary from 04/11/26 and discovered there had been transcription errors with Resident #1's Keppra and Eliquis medications.The DON said that it is the Facility's expectation to have the admitting nurse review the resident's Hospital DC summary, any other sources of medications the resident had been receiving and enter the results into PCC.The DON said a second nurse must review the medication list printed from PCC and review for any errors. The DON said once verified, the admitting nurse will notify the provider of the medications, and any discrepancies will be documented onto their newly implemented medication reconciliation form and clarified by the provider. The DON said after medication reconciliation is completed, the next shift will review the reconciliation for potential errors and said she reviews all medication reconciliation forms as well as the Medical Director.On 05/13/26, the Facility staff presented the Surveyor with a plan of correction with an effective date of 04/30/26 that addressed the area of concern identified in this survey, as follows:A) Resident #1 was transferred to the Hospital Emergency Department for evaluation and was admitted .B) On 04/21/26, the Hospital Staff notified the DON regarding the omission of Resident #1's anticonvulsant medication (Keppra).C) On 04/21/26 and 04/22/26, Nurse #1 was educated by the DON regarding the Facility's policy and procedures related to medication reconciliation process.D) On 04/21/26 through 04/29/26, Nursing Staff were educated by the DON and/or designee regarding the Medication Reconciliation process, need to complete the newly (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	implemented medication reconciliation form and the Electronic Medication Administration Record (EMAR) Medication Entry Process (which also included a written test and observations for competency conducted by the DON and/or designee).E) On 04/22/26 an Ad [NAME] Quality Assurance Performance Improvement (QAPI) meeting was held by Facility Management to review the incident, which included development and implementation of a Plan of Correction (POC).F) On 04/23/26, the [NAME] President (VP) of Clinical Services and the DON began a retrospective 30-day audit of all previous admissions and readmissions, during that time period.G) On 04/23/26 the V.P. of Clinical Services educated the DON regarding the timeliness of monitoring recommendations received from the Pharmacy.H) On 04/27/26 and 04/28/26, the Medical Director and primary Nurse Practitioner were educated by the DON and VP of Clinical Services regarding the Medication Reconciliation Process.I) An audit of all admissions and readmissions medication reconciliation forms will be completed 3 x week x 4 weeks, followed by weekly audits for the next 4 months or until compliance is achieved.J) The results of the audits will be brought to QAPI monthly x 3 months or until compliance is achieved.K) The DON and/or designee are responsible for overall compliance.