

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Royal Cape Cod Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8 Lewis Point Road Buzzards Bay, MA 02532	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose physicians' orders included the administration of Methadone (opioid, narcotic) 10 milligrams (mg) daily, the Facility failed to ensure he/she was free from a significant medication error, when on 02/25/25 nursing staff did not properly identify the resident's name or dosage on the medication bottle and administered another residents' methadone to him/her. As a result of Resident #1 being administered 110 mg of Methadone (not 10 mg as ordered), he/she was transferred to the Hospital Emergency Department (ED) for evaluation and required treatment for adverse side effects related to an overdose of Methadone.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled, Administering Medications, undated, indicated the following:</p> <ul style="list-style-type: none"> -only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so; -medications are administered in accordance with prescriber orders; -the individual administering medications verifies the resident's identity before giving the resident his/her medications; -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; -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. <p>Review of the Facility's Policy titled, Medication Error, dated March 2024, indicated the following:</p> <ul style="list-style-type: none"> -it is the policy of the facility to assure that each medication administered to our resident has been prescribed by a licensed physician or equivalent; <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>-noncompliance with the exact medication order is considered a medication error;</p> <p>-medication errors include: omission, wrong drug, wrong patient, wrong dose, wrong time, wrong route, given not charted, extra dose found, documentation error and transcription.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 02/27/25, indicated that on 02/25/25 Resident #1 mistakenly received the wrong dose of Methadone in error. The Report indicated that Resident #1 received 110 mg of Methadone instead of his/her physician ordered 10 mg of Methadone. The Report indicated that Resident #1's Physician was notified and he/she was transferred to the Hospital ED for evaluation and monitoring.</p> <p>The Report indicated that the Nurse was administering scheduled medications to Resident #1 when the incorrect bottle of sealed premeasured Methadone was retrieved and administered to Resident #1 in error. The Report indicated that the Nurse mistakenly retrieved a bottle of Methadone that was labeled for another resident (later identified as Resident #3) and administered the incorrect dose of Methadone to Resident #1. The Report indicated that the Nurse noted her error during narcotic count with the oncoming shift.</p> <p>Review of drug information specific to Methadone via Drugabuse.com, dated 08/08/2024, indicated Methadone is a long-acting opioid agonist that works by reducing the effects of other opioid's. Methadone can, however, be misused when someone takes it in a way other than prescribed or by taking more than prescribed. If someone takes more than prescribed (intentionally or unintentionally), there is an increased risk of overdose due to potential respiratory depression. Signs and symptoms of Methadone overdose include difficulty waking up, slowed or shallow breathing, vomiting, decreased heart rate, extreme drowsiness, or sleepiness, mental confusion, difficulty awakening, low blood pressure and slurred speech.</p> <p>Review of Resident #1's Hospital Discharge Summary, dated 02/26/25, indicated that Resident #1 presented to the ED for an accidental overdose of Methadone. The Summary indicated that upon arrival at the ED, Resident #1 complained of increased somnolence (sleepiness) and nausea which resolved with Zofran (receptor antagonist used for nausea and vomiting). The Summary indicated that Resident #1 received 110 mg of Methadone instead of his/her 10 mg of Methadone and was admitted to the Telemetry Unit (continuous tracking of your hearts electrical activity) for monitoring and an EKG (electrocardiogram - test that measures the electrical waves in the heart) testing every four hours due to such a high dose of Methadone.</p> <p>Resident #1 was admitted to the Facility in November 2024, diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease, adjustment disorder with anxiety, depression, psychoactive substance abuse, cirrhosis of liver, portal hypertension, atrial fibrillation, chronic viral hepatitis C, obstructive sleep apnea and morbid obesity.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS), dated [DATE], indicated that he/she was cognitively intact.</p> <p>Review of Resident #1's Medication Administration Record (MAR) and Physician Orders, dated February 2025, indicated that he/she had an active physician's order for Methadone 10 mg daily.</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>Review of Resident #3's Physician Orders, dated February 2025, indicated that he/she had an order for Methadone 110 mg by mouth once daily, for pain.</p> <p>Review of Resident #1's Medication Variance Report, dated 02/25/25, indicated that Resident #1 received 110 mg of Methadone instead of his/her 10 mg dose of Methadone in error. The Report indicated Resident #1's Physician was notified and he/she was transferred to the Hospital ED for evaluation.</p> <p>Review of Resident #1's Nurse Progress Note, dated 02/25/25, indicated that he/she was inadvertently given an extra 100 mg of Methadone and was transferred to the Hospital ED immediately.</p> <p>Review of Resident #1's Provider Progress Note, dated 02/25/25, indicated that he/she received an extra 100 mg of Methadone in error and was transferred to the Hospital ED.</p> <p>During an interview on 04/01/25 at 11:15 A.M., Resident #1 said that on 02/25/25, he/she was administered 110 mg of Methadone in error and had to go to the hospital for treatment. Resident #1 said that he/she experienced lethargy and nausea from the overdose of Methadone. Resident #1 said that he/she is anxious now every time the nurse administers his/her medications because he/she is afraid that the nurse may give him/her the wrong medication and that he/she looks at the medications in the cup to be sure the medications are correct.</p> <p>During an interview on 04/01/25 at 12:10 P.M., Nurse #3 said that on 02/25/25 at approximately 7:15 A.M. she did narcotic count with Nurse #1. Nurse #3 said that during the count, they discovered that the narcotic count was incorrect for Resident #1's Methadone. Nurse #3 said she and Nurse #1 looked in the narcotic drawer and noticed that Resident #3's Methadone 110 mg bottle for the 02/25/25 dose was missing, and that Resident #3 was at the hospital and would not have received his/her Methadone dose that morning. Nurse #3 said that was when Nurse #1 realized that she had administered Resident #3's Methadone (110 mg) to Resident #1 in error. Nurse #3 said that Resident #1's Methadone 10 mg bottle for the 02/25/25 dose was still in the narcotic drawer when she did narcotic count with Nurse #1.</p> <p>During a telephone interview on 04/02/25 at 11:16 A.M., (which included review of her interview conducted and documented by the Director of Nurses), Nurse #1 said she worked the 11:00 P.M. to 7:00 A.M. shift on 02/25/25. Nurse #1 said that there were three residents on the unit who received Methadone. Nurse #1 said that Methadone was stored in a separate secured narcotic drawer and each resident had individual bottles with their name, dose and date to be administered on it, that were separated in the narcotic drawer by resident. Nurse #1 said she went into the narcotic drawer, saw the date of 02/25/25 on a Methadone bottle and took it out of the draw, but did not look at the dosage or residents name on the bottle when she removed it from the drawer.</p> <p>Nurse #1 said that she went to Resident #1's room and administered the Methadone to him/her, again without looking at the dosage or residents name on the bottle prior to administering it to him/her. Nurse #1 said that during narcotic count at the end of her shift with Nurse #3, they discovered that Resident #1's Methadone count was incorrect and that was when she realized that Resident #1 had received the wrong dose of Methadone. Nurse #1 said she had administered Resident #3's Methadone 110 mg to Resident #1 in error. Nurse #1 said she should have looked at the Methadone bottle to see whose name was on the bottle and checked the dosage of Methadone but had not. Nurse #1 said she just looked at the date on the bottle and did not follow the proper procedures for medication administration.</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 04/01/25 at 3:30 P.M., the Director of Nurses (DON) said she was made aware of Resident #1's medication error on 02/25/25 by Nurse #1. The DON said that Nurse #1 informed her that she had administered 110 mg of Methadone to Resident #1 in error. The DON said that Nurse #1 said she did not look at the name or dose that was on the Methadone bottle. The DON said it was her expectation that nurses follow the rights of medication administration, read the label on the medication bottle to be sure that the medication is for the correct resident and that the dose is correct prior to administering any medications to residents.</p> <p>On 04/01/25, 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 02/25/25, Resident #1 was assessed by nursing and transferred to the Hospital ED for evaluation and treatment.</p> <p>B. On 02/25/25 Nurse #1 was educated by the Director of Nurses on the Facility's Policy and Procedure on Medication Administration.</p> <p>C. On 02/25/25, a Methadone Storage Audit was completed and each resident on Methadone and each resident now has an individual zippered storage bag with their name on it and all of their individual Methadone bottles secured in the sealed bag.</p> <p>D. On 02/26/25, a Quality Assurance Performance Improvement (QAPI) Committee meeting was held regarding medication administration and reduction of medication errors.</p> <p>E. On 02/27/25, a Root Cause Analysis Summary was completed on medication errors.</p> <p>F. On 03/10/25, Licensed staff were educated by the Corporate Nurse on the Facility's Medication Administration Policy and the Medications for Addiction Treatment (MAT) Policy.</p> <p>G. On 03/25/25, the Facility's Controlled Substance Administration and Accountability Policy and Procedure and Medication Error Policy was revised by the Regional Nurse Consultant.</p> <p>H. The Unit Manager and/or designee will conduct weekly audits on Methadone Storage to ensure that each resident on Methadone has an individual zippered bag with their name on it and their Methadone bottles are in the bag. Audits will be done weekly for 3 months and will continue until overall compliance is achieved.</p> <p>I. 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>J. The Director of Nursing and/or designee are responsible for overall compliance</p>		