

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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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  07/15/2025
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)
F 0711  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.  (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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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose Hospital Discharge Summary included a diagnosis of atrial fibrillation (irregular heartbeat) with an order for Xarelto (anticoagulant), the facility failed to ensure the Physician and Nurse Practitioner completed a review of his/her total program of care, including reviewing for accuracy Resident 1's medications, as a result he/she did not receive Xarelto for 13 days. Findings Include: Review of the Facility's Policy titled, Medication Reconciliation Policy, dated as revised January 2025, indicated the following:-the facility reconciles medication to ensure that the resident is free of any significant medication errors.-medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff. Resident #1 was admitted to the Facility in June 2025, diagnoses included right femoral (thigh bone) fracture, heart failure, atrial fibrillation (irregular heart rate), aortic stenosis (narrowing of the valve in the large blood vessel branching off the heart), hypertension and hyperlipidemia (high cholesterol). Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated his/her discharge medications orders included but not limited to the following:-Rivaroxaban (Xarelto, an anticoagulant) 20 milligrams (mg) tablet, one tablet (20 mg total) by mouth daily Review of Resident #1's Nurse Practitioner (NP) Progress Notes, dated 06/09/25, 06/10/25, 06/13/25 and 06/16/25 indicated that Resident #1 had a diagnosis of atrial fibrillation and he/she was seen and examined. The Notes indicated that Resident #1's medications were reviewed and reconciled and to see Medication Administration Record (MAR). The Notes indicated that Resident #1's assessments/plans were to continue current medications for his/her diagnosis of atrial fibrillation. However, further review of Resident #1's NP Progress Notes indicated that Xarelto was not listed under his/her medications. Review of Resident #1's Physician admission Progress Note, dated 06/11/25 indicated that Resident #1 had a history of atrial fibrillation and he/she was on Xarelto. The Note indicated Resident #1's assessments/plans were to continue current medications and current management for his/her diagnosis of atrial fibrillation. However, further review of the Note indicated that although it included a list of Resident #1's medications, it did not include Xarelto. During an interview on 7/16/25 at 10:39 A.M., the Nurse Practitioner (NP) said she reviewed Resident #1's Hospital Discharge Summary and saw him/her on 06/09/25, 06/10/25, 06/13/25 and 06/16/25. The NP said she could not recall if Xarelto was listed on Resident #1's physician orders or medication list and said, I plead the fifth and will not further comment. During an interview on 7/16/25 at 11:04 A.M., the Physician said he saw Resident #1 once (could not recall date), he reviewed his/her Hospital Discharge Summary, and he/she was on Xarelto for atrial fibrillation. The Physician said the medication list in his progress notes was not a reconciliation list of medications. The Physician said he was not aware that Resident #1 had not received his/her Xarelto until he/she was sent to the Hospital ED. The Physician said the On-call provider reviewed, reconciled and approved Resident #1's admission orders with the admitting nurse and that the admitting nurse had not transcribed Xarelto onto Resident #1's admission orders. During an interview on 7/15/25 at 2:45 P.M., the Director of Nursing (DON) said Resident #1 had been seen by the Physician and the Nurse Practitioner after his/her admission. The DON said she reviewed Resident #1's Physician and Nurse Practitioner progress notes which included he/she had atrial fibrillation and to continue current medications, but the DON said, Xarelto was not listed under his/her medications. The DON said she spoke with the Physician, and he said that he reviewed Resident #1's Hospital paperwork, saw that Resident #1 was on Xarelto, but that he had not done a comparison to the medications that were entered into PCC by the admitting nurse. The DON said the NP told her that she (NP) had looked at Resident #1's Hospital paperwork, but said that she had not done a formal comparison of his/her medication orders. The DON said it was her expectation that the Physician and Nurse Practitioner reviewed and reconciled residents' orders against their Hospital Discharge Summary, that their orders entered in Point Click Care (PCC, electronic medical record system) match and residents' medications should be documented accurately in the residents' Physician and NP progress notes. On 07/15/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 06/26/25, which addressed the area(s) of concern as evidenced by: A. Resident #1 is no longer in the Facility. B. On 06/19/25, the Director of Nursing and [NAME] President of Operations completed a house audit on all residents admitted in the past 30 days to ensure medications were ordered and administered per Hospital Discharge paperwork C. On</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose Hospital Discharge Summary included a diagnosis of atrial fibrillation (irregular heart beat) with an order for Xarelto (anticoagulant), the Facility failed to ensure he/she was free from significant medication errors, when upon admission Resident #1's physician orders were not accurately reconciled and transcribed by nursing staff, he/she was not administered Xarelto for thirteen days, placing him/her at increased risk for adverse reactions. Findings Include:Review of the Facility's Policy titled, admission Assessment and Follow Up: Role of the Nurse, dated May 2023, indicated nursing would reconcile the list of medications from the medication history, admitting orders, and the discharge summary from the previous institution, according to established procedures.Review of the Facility's Policy titled, Medication Reconciliation Policy, dated as revised January 2025, indicated the following:-the facility reconciles medication to ensure that the resident is free of any significant medication errors.-medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff. -admission processes: compare orders to hospital records, obtain clarification orders as needed, and transcribe orders in accordance with procedures for admission orders.Review of Resident #1's Medication Variance Report, dated 06/18/25, indicated that Resident #1's medication as ordered for Xarelto 20 mg daily was missed during transcription of his/her admission orders and on 24-hour check by the 11:00 P.M.-7:00 A. M. nurse. The Report indicated that Resident #1 had not received his/her Xarelto medication for 13 days, his/her physician was notified, and he/she was transferred to the Hospital Emergency Department for evaluation.Review of an article in Drugs.com the Official Website, dated 07/25/24, indicated Xarelto (rivaroxaban) class of medications called factor Xa inhibitors (used as anticoagulants, blood thinners). It works by blocking the action of a certain natural substance that helps blood clots to form. Xarelto is used to treat or prevent blood clots (venous thromboembolism, or VTE), blood clots can occur in the legs (deep vein thrombosis, DVT) or the lungs (pulmonary embolism, PE). The Website further indicated Xarelto is also used to help prevent strokes or serious blood clots in adults who have atrial fibrillation, (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) that is not caused by heart valve disease.Resident #1 was admitted to the Facility in June 2025, diagnoses included right femoral (thigh bone) fracture, heart failure, atrial fibrillation (irregular heart rate), aortic stenosis (narrowing of the valve in the large blood vessel branching off the heart), hypertension and hyperlipidemia (high cholesterol).Review of Resident #1's admission Minimum Data Set (MDS), dated [DATE], indicated that he/she was cognitively intact.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated his/her discharge medications orders included but not limited to the following:-Rivaroxaban (Xarelto, an anticoagulant) 20 milligrams (mg) tablet, one tablet (20 mg total) by mouth dailyReview of Resident #1's Nurse Progress Note, dated 06/18/25, indicated that at approximately 7:50 A.M. he/she was SOB, O2 Saturation was 86% on room air, his/her right arm was flaccid with weakness, and he/she was leaning to his/her right. The Note indicated that O2 (four liters) was applied to Resident #1 via nasal cannula, and an order was obtained to send him/her to the Hospital ED for evaluation and treatment per the Nurse Practitioner.During an interview on 7/15/25 at 1:25 P.M., (which included review of her written statement) Nurse #1 said she worked the 3:00 P.M. to 11:00 P.M. shift on 06/05/25 and had done Resident #1's admission that night. Nurse #1 said she reviewed Resident #1's Hospital Discharge paperwork, verified all medication orders with the on-call provider, then entered them into the Point Click Care (PCC, electronic medical record system) from his/her hospital medication list. Nurse #1 said she thought she had entered all of Resident #1's medications including his/her order for Xarelto and said she had no clue that she had not entered the order for Xarelto. Nurse #1 said she must have missed entering the Xarelto order because she could have been distracted by being called away to attend to another resident.During an interview on 7/17/25 at 8:56 A.M., (which included review of her written statement) Nurse #2 said she worked the 11:00 P.M. to 7:00 A.M. shift on 06/05/25 into 06/06/25 and there were two new admissions on the previous shift (3:00 P. M. to 11:00 P.M.). Nurse #2 said she completed one of the admissions and had started to do the second check on Resident #1's admission orders. Nurse #2 said she was called away by the Certified Nurse Aide (CNA) on the unit because the CNA needed assistance with another resident. Nurse #2 said she informed the on-coming shift nurse (could not recall the exact name) that she was not able to complete the second</p>		