| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225562 | A. Building<br>B. Wing | 05/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oc Milford Gardens LLC | 10 Veterans Memorial Drive<br>Milford, MA 01757 |

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) |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on record reviews and interviews for one of three sampled residents (Resident #1), who was alert, oriented and newly admitted to the facility, the Facility failed to ensure that they obtained signed written informed consent for the administration of psychotropic medication, Buspirone, which include providing the resident with information related to the risks and benefits of the medication, prior to it being administered.Findings include:Review of the Facility Policy Psychotropic Consent, dated as last revised 02/2021, indicated the following:-the facility will obtain informed written consent prior to administration of any psychotropic medication;-psychotropic medications include: antipsychotic, antidepressant, antianxiety and hypnotic medications;-prior to the administration of a psychotropic medication, the prescribe must discuss the purpose for administering the psychotropic drug, the prescribed dosage and any known effect or side effect of the psychotropic medication with the resident;-prior to administration of a psychotropic medication, the facility representative must complete the Informed Consent for Psychotropic Administration Form;-prior to administration of a psychotropic medication, the resident must sign and date the Informed Consent for Psychotropic Administration Form;-after verifying completion of the Informed Consent for Psychotropic Administration Form and verifying all required signatures have been obtained, the facility representative will sign and date the form and notify nursing of the fully approved consent;-the completed Informed Consent for Psychotropic Administration Form will be maintained in the resident's medical record.Resident #1 was admitted to the Facility in March 2026, diagnoses included acute renal failure on top of chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms, hyponatremia, hypomagnesemia, hypocalcemia, atrial fibrillation, hyperlipidemia, hypertension, chronic gout due to renal impairment, and Wegener's granulomatosis with renal involvement (autoimmune disease that can affect your whole body, but especially affects your lungs and kidneys).Review of Resident #1's admission Minimum Data Set (MDS) Assessment, dated 03/16/26, indicated he/she was alert, oriented, was his/her own decision maker, and had scored a 15/15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact).Review of Resident #1's Physician's Orders, dated 03/11/26 through 03/16/26, indicated to administer the following;-Buspirone HCL (anxiolytic) 10 mg by mouth three times daily;Review of Resident #1's March 2026 Medication Administration Record (MAR), dated 3/11/26 through 3/16/26, indicated that he/she had been administered 16 doses of Buspirone HCL.Further review of Resident #1's Medical Record indicated there was no documentation to support that a written informed consent was obtained from Resident #1 for administration of Buspirone HCL. During a telephone interview on 5/20/26 at 10:58 A.M., Nurse #1 said that Buspirone is an antianxiety medication and requires completion of an informed written consent before being administered to the resident. Nurse #1 said she administered Buspirone to Resident #1 as ordered by the physician and documented it in the MAR. Nurse #1 said that it is the facility's policy to obtain written informed consent for the administration of all psychotropic medications prior to the administration of the medication and said she thought that the Unit Manager had obtained written informed consent from Resident #1 for the administration of Buspirone. Nurse #1 said she did not check Resident #1's<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medical record for an informed consent prior to administering him/her Buspirone.During a telephone interview on 5/20/26 at 12:12 P.M., the Unit Manager said that Buspirone is an antianxiety medication and requires completion of an informed written consent before being administered to the resident. The Unit Manager said that it is the staff nurse's responsibility and facility policy to obtain written informed consent for any psychotropic medication prior to the administration of the medication. The Unit Manager said that she did not obtain written informed consent from Resident #1 for the Buspirone and said she was unaware that Resident #1's psychotropic medication consent had not been obtained by the staff nurse.During an interview on 5/19/26 at 3:00 P.M., the Director of Nurses (DON) said it is the Facility's policy that a written informed consent be obtained prior to the administration of psychotropic medication. The DON said she was unable to locate documentation to support that the Facility had obtained an informed written consent for the administration of Resident #1's psychotropic medication Buspirone HCL. The DON said it was her expectation that an informed written consent be obtained prior to the administration of any psychotropic medication. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews for one of three sampled residents (Resident #1), who was newly admitted to the facility, the Facility failed to ensure he/she was free from a significant medication error, when medications from his/her Hospital Discharge Summary were not accurately reconciled by Nursing and he/she was administered Buspirone (anxiolytic medication) and Benzonatate (cough suppressant) in error.Findings include:Review of the Facility Policy titled, Reconciliation of Medications on Admission, dated as revised 04/2025, indicated the following:-medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route and indication for use for the purpose of preventing unintended changes or omissions at transition points in care;-obtain a medication history from the resident or family, complete this first;-gather the information needed to reconcile the medication list - Discharge Summary from referring facility;-find a quiet place that is free from distractions;-review the list carefully to determine if there are any discrepancies;-if there is a discrepancy or conflict in medications, dose, route or frequency, contact the nurse and physician from the referring facility, discuss with the resident or family, and contact the admitting physician;-document findings and actions of the medication discrepancy.Review of the Facility Policy titled Adverse Consequences and Medication Errors, dated as revised 7/2025, indicated that a medication error is defined as the administration of drugs which is not in accordance with physician's orders or accepted professional standards and principles of the professional's providing services.Resident #1 was admitted to the Facility in March 2026, diagnoses included acute renal failure on top of chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms, hyponatremia, hypomagnesemia, hypocalcemia, atrial fibrillation, hyperlipidemia, hypertension, chronic gout due to renal impairment, and Wegener's granulomatosis with renal involvement (autoimmune disease that can affect your whole body, but especially affects your lungs and kidneys).Review of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 3/18/26, indicated that Resident #1 was on a medication that he/she did not give consent to be administered. The Report indicated that Resident #1's medication list was reviewed and a discrepancy related to Buspirone was identified. The Report indicated that the nurse who reviewed Resident #1's admission medications accidentally made a mistake during the transcription of the medications and made a medication error due to having two admissions at the same time and being interrupted during the medication reconciliation. The Report indicated that Resident #1 received several doses of Buspirone in error while at the facility.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated to administer the following:-Calcitriol (Vitamin D Supplement) 0.25 micrograms (mcg) by mouth daily;-Prednisone (corticoid steroid) 5 milligrams (mg) by mouth daily;-Carvedilol (beta-blocker) 12.5 mg by mouth twice daily;-Docusate Sodium (stool softener) 100 mg by mouth daily at bedtime;-Docusate Sodium (stool softener) 200 mg by mouth daily;-Famotidine (histamine-2 blocker) 20 mg by mouth twice daily;-Calcium Carbonate (Mineral Supplement) 500 mg chewable tablet by mouth daily;-Cholecalciferol (Vitamin D3 Supplement) 2000 Unit by mouth daily;-Atorvastatin (statin) 20 mg by mouth daily;-Mycophenolate Mofetil (immunosuppressive) 500 mg by mouth daily at bedtime;-Mycophenolate Mofetil 1000 mg by mouth daily;-Tamsulosin (alpha blocker) 0.4 mg by mouth daily at bedtime;-Eliquis (anticoagulant) 2.5 mg by mouth twice daily;-Lactobacillus Acidophilus (probiotic) one capsule by mouth daily;-Fosfomycin Tromethamine (antibiotic) 3 gram packet by mouth every week on Friday;-Amlodipine (calcium channel blocker) 5 mg by mouth daily;-Metoclopramide HCL (dopamine receptor antagonist) 5 mg by mouth daily;-Allopurinol (antigout) 100 mg by mouth daily.However, further review of Resident #1's Facility Physician's Orders, dated 03/11/26, indicated that it included the administration of two additional medications: -Buspirone HCL<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (anxiolytic) 10 mg by mouth three times daily;-Benzonatate (cough suppressant) 100 mg by mouth three times daily.Further review of Resident #1's Hospital Discharge summary, dated [DATE], indicated the medication list did not include the administration of Buspirone and Benzonatate.Review of Resident #1's Medical Record indicated that there was no documentation to support that nursing clarified, reconciled or obtained new orders regarding the Buspirone and Benzonatate medications from his/her Physician upon admission.Review of a Nurse Practitioner Progress Note, dated 3/11/26, indicated that Resident #1 arrived today for admission, medications reviewed with Unit Manager, will see [resident] tomorrow for full assessment and note.Review of a Nurse Practitioner Progress Note, dated 3/12/26, indicated that per discharge papers and patient, the hospital had issues confirming medication dosing and patient confirms dosing in the hospital discharge paperwork and we will continue through his/her stay. During an interview on 5/19/26 at 1:20 P.M., Nurse Practitioner (NP) #1 said that she reviewed Resident #1's Hospital Discharge summary dated , 3/11/26, with the Unit Manager and said that everything looked appropriate. NP #1 said that she did not add any new medications [Buspirone and/or Benzonatate] to the medications listed on Resident #1's Hospital Discharge Summary.Review of Resident #1's March 2026 Medication Administration Record (MAR), indicated that he/she received the following medications in error:-Buspirone HCL 10 mg was administered three times a day from 3/11/26 until 3/16/26, for a total of 16 doses;-Benzonatate 100 mg was administered three times a day from 3/11/26 until 3/16/26, for a total of 16 doses.During a telephone interview on 5/20/26 at 10:58 A.M., Nurse #1 said that on 3/11/26 there were three new admissions/re-admissions to her Unit. Nurse #1 said that the Unit Manager completed the medication reconciliations from the Hospital Discharge Summary and entered the medications into the Electronic Medication Administration Record (EMAR) for the three admissions.Nurse #1 said that she did not review the medication list on the Hospital Discharge Summary for Resident #1 and administered the medications to Resident #1 that were on the EMAR. Nurse #1 said that the NP did not order any new medications for Resident #1.During a telephone interview on 5/20/26 at 12:12 P.M., the Unit Manager said that on 3/11/26 she had three new admissions/re-admissions to her Unit. The Unit Manager said that she reviewed all the three admissions Hospital Discharge Summary's and completed the medication reconciliations.The Unit Manager said that she was interrupted many times during the medication reconciliations and entered the Buspirone medication into Resident #1's Medication Administration Record in error. The Unit Manager said that she must have mixed up Resident #1's medication list with one of the other two admissions medication lists in error. The Unit Manager said that she verified Resident #1's medications with the NP on 3/11/26 and said that the NP did not order any new medications for Resident #1.Although the Unit Manager acknowledged that she transcribed the Buspirone error, the Surveyor identified during the survey that Benzonatate had also been entered and transcribed into Resident #1's Medication Administration Record during medication reconciliations on 3/11/26, in error. The Facility's Internal Investigation into the transcription error related to the Buspirone, however failed to identify that a second medication [Benzonatate] had also been transcribed onto Resident #1's EMAR in error.During an in-person interview on 5/19/26 at 3:00 P.M. and a subsequent telephone interview on 5/21/26, the Director of Nurses (DON) said the facility was notified by Resident #1's family member that Resident #1's medication list was wrong and that he/she received a medication (Buspirone) at the facility in error. The DON said that upon this notification, she immediately reviewed Resident #1's Hospital Discharge summary dated [DATE] and noticed that the Buspirone was not on his/her medication list from the Hospital Discharge Summary. The DON said that there were multiple admissions on 3/11/26, that the Unit Manager had reviewed Resident #1's Hospital Discharge Summary medication list, completed the medication reconciliation, and entered the Buspirone in error into Resident #1's EMAR. The DON said that the Unit Manager had multiple interruptions and transcribed the Buspirone from another resident's Hospital Discharge Summary medication list onto Resident #1's EMAR in error.The DON said that she reviewed Resident #1's admission the following day and verified that all of the medications that were listed on the<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Hospital Discharge Summary were on the EMAR. The DON said that she did not check to see if there were any additional medications on the EMAR and did not notice that the Buspirone was not listed on the Hospital Discharge Summary.During the survey on 5/21/26, while reviewing Resident #1's MAR, the Surveyor noted that Resident #1 also received Benzonatate, which was also not listed on his/her Discharge Summery, and he/she therefore had also received that medication in error. The DON, when informed of the additional transcription/medication error, said that she was unaware that Benzonatate was administered in error and said she would look into it.The DON said that she completed another chart audit on Resident #1's Medical Record after she was notified of the medication error and said that she did not notice that Resident #1 had also received Benzonatate in error. The DON said that it was her expectation that residents receive medications according to the providers orders, that medication reconciliation is completed accurately upon admission and any discrepancies clarified with the provider and documented in the Medical Record. |