

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/11/2025
NAME OF PROVIDER OR SUPPLIER  Hadley Center for Nursing Rehab & Care		STREET ADDRESS, CITY, STATE, ZIP CODE  20 North Maple Street Hadley, MA 01035	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on record review and interviews, for one of three sampled residents (Resident #3), who required medication to treat hypotension (low blood pressure) and had a Physician's order to hold (not administer) the medication for a systolic blood pressure (SBP-top number, represents the pressure in arteries when the heart contracts) greater than 115, the Facility failed to ensure the resident was free from significant medication errors when he/she was administered the medication outside of the prescribed parameter, placing him/her at risk for high blood pressure.</p> <p>Findings include:</p> <p>Review of the Facility policy titled, General Dose Preparation and Medication Administration, revised 01/01/22, indicated facility staff should:</p> <ul style="list-style-type: none"> <li>-comply with Facility policy, applicable law and the State Operations Manual when administering medications,</li> <li>-verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in the facility's medication administration schedule,</li> <li>-confirm that the MAR reflects the most recent medication order,</li> <li>-if necessary, obtain vital signs.</li> </ul> <p>Resident #3 was admitted to the Facility in October 2023, diagnoses included Parkinson's Disease (a nervous system disorder that affects movements, often including tremors) and dementia.</p> <p>Review of Resident #3's Physicians' Order for May 2025, indicated it included orders for, but not limited to the following:</p> <p>Midodrine HCL (medication used to treat low blood pressure) oral tablet 5 milligrams (mg), give one tablet by mouth three times a day for hypotension (low blood pressure). Hold (do not give) for blood pressure with systolic (pressure) greater than 115 or diastolic (pressure) greater than 80, start date 08/21/24.</p> <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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #3's Medication Administration Record (MAR) for May 2025, indicated he/she was administered Midodrine HCL 5 mg by nursing, despite having (per nursing documentation) a systolic pressure reading that was greater than 115, (and therefore per MD orders it should have been held) on the following dates/times:</p> <p>05/01/25 at 8:00 A.M., BP-126/75</p> <p>05/10/25 at 2:00 P.M.-BP-116/74</p> <p>05/11/25 at 8:00 A.M.-BP-157/67</p> <p>05/11/25 at 2:00 P.M.-BP-122/70</p> <p>05/12/25 at 8:00 A.M.-BP-122/52</p> <p>05/14/24 at 5:00 P.M.-BP-124/70</p> <p>05/17/25 at 8:00 A.M.-BP-125/67</p> <p>05/17/25 at 2:00 P.M.-BP 116/75</p> <p>05/17/25 at 5:00 P.M.-BP-118/70</p> <p>05/18/25 at 2:00 P.M.-BP-116/70</p> <p>05/31/25 at 2:00 P.M.-BP-118/64</p> <p>During an interview on 06/11/25 at 3:30 P.M., Nurse #1 said she should not have administered Midodrine to Resident #3 on 05/01/25 and 5/12/25 at 8:00 A.M. when his/her systolic blood pressure was above 115.</p> <p>During an interview on 06/11/25 at 3:30 P.M., the Director of Nurses (DON) said it is the Nurses' responsibility to follow the Physician's orders on the medication administration record (MAR). The DON and the surveyor reviewed Resident #3's MAR for May 2025 and the DON said Resident #3 should not have received Midodrine on the eleven instances when his/her systolic blood pressure was documented above 115, by nursing.</p>