STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225720	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Millbury	312 Millbury Avenue Millbury, MA 01527

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. 40702 Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose diagnoses included atrial fibrillation (irregular heartbeat) with a Physician's order for an anticoagulant (blood thinner) medication to manage the condition, the Facility failed to ensure he/she was free from significant medication errors, when due to a transcription error by nursing, Resident #1 was administered two different anticoagulant medications for five days and on 1/24/24 he/she was found to have blood in his/her stool, blood laboratory work indicated he/she had a critical low hemoglobin (helps red blood cells carry oxygen to muscles and tissues) level, he/she was transferred to the Hospital Emergency Department (ED) for evaluation and required admission for further treatment. Findings Include: Review of the Facility Policy titled, Physician Orders: Obtaining and Transcribing, dated as revised 09/29/2015, indicated the following: -directive known as Physician Orders will be obtained to manage the medical condition and plan of care for each resident -physician orders can be obtained in person, verbally via telephone or written (in person, via fax, or via referral, consult, or other source) -the professional nurse (RN, LPN) per scope of practice defined by State law/practice acts) is responsible for the transcription of orders such as telephone orders -physician orders (recapitulations/renewals, telephone/verbal) or faxed orders are to be noted by a licensed nurse by writing: noted, date & time, and signature and title -high risk medications: medications that have an increased potential for causing harm if used in error and the consequences of those errors can be devasting; medications identified as high risk in this setting are: insulin, warfarin/coumadin, and heparin -validate (a physician order): review of a physician order that has been received or verified by another nurse to ensure it is a complete order that reflects the order(s) of the consult, referral, etc. or documented changes to those orders; that transcription of the orders is complete and correct; and that follow-through has been implemented (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	-when a physician changes a physician order that is currently in place, the original order must be discontinued first, and a new order written that reflects the change -new or changed orders for high alert medications will be validated and noted by a second nurse Resident #1 was admitted to the Facility in September 2023, diagnoses included atrial fibrillation, hypertension, gastrointestinal hemorrhage, melena (black stool), anemia, and atherosclerotic heart disease. Review of Resident #1's Facility Medication Error Report, dated 1/24/24, indicated that Nurse #1 had not transcribed part of a medication order that she received from Resident #1's Physician on 1/17/24. The Report indicated Nurse #1 had not discontinued Resident #1's order for Xarelto (anticoagulant) after she entered the new order for Pradaxa (anticoagulant), which resulted in Resident #1 receiving both anticoagulant medications. Review of the Facility Investigation Report, dated 1/24/24, indicated that Resident #1's Xarelto was to be discontinued and he/she was to start Pradaxa, per Physician's order. The Report indicated Nurse #1 transcribed the Physician's order incorrectly and had not discontinued Resident #1's Xarelto and he/she received both anticoagulants from 1/20/24 through 1/24/24. The Report indicated Resident #1 developed rectal bleeding, was examined by the Physician and during review of his/her medical record, the Physician discovered that Resident #1 had been receiving two anticoagulant medications for several days. The Report further indicated that Resident #1 had a stat (immediate priority) hemoglobin (Hgb) blood level drawn, results showed a low level of 5.3 grams per deciliter (g/dl) (normal range 12.0-16.0 g/dl) and he/she was transferred to the Hospital Emergency Department for treatment. During an interview on 4/03/24 at 1:04 P.M., the Nurse Practitioner (NP) said she saw Resident #1 on 1/17/24 because he/she was having nausea, dizziness, diarrhea and his/her blood pressure was low. The NP said she assessed Resident #1, observed that he/she had black stool (sign of a problem in the upper digestive system, often indicates bleeding in the stomach) and ordered nursing to hold his/her Xarelto times one day (hold the 1/18/24, 9:00 A.M. dose). The NP said she also ordered laboratory blood work be obtained which included a complete blood count (CBC) drawn on 1/18/24 and an x-ray of his/her kidney, ureter, and bladder (KUB). The NP said Resident #1's laboratory results showed that his/her hematocrit (Hct) level was low at 22.0 % (normal range 36.0 % - 46 %) and his/her hemoglobin (Hgb) level was also low at 7.2 g/dl. The NP said that although Resident #1's hematocrit and hemoglobin (H&H) levels were low, they were not far off from his/her previous H&H that was done on 12/13/23 and said she ordered another CBC to be drawn in one week, on 1/25/24. Review of Resident #1's Medication Administration Record (MAR) indicated that his/her Xarelto was not held on 1/18/24, as ordered by the NP, but instead was administered at 9:00 A.M., by nursing. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Physician (MD) Communication Form, dated 1/17/24, (written by Nurse #1), indicated that Nurse #1 received a phone call from the Oncology NP with a recommendation to switch Resident #1 from Xarelto to Pradaxa 150 mg two times a day before he/she started chemotherapy in February 2024. The Physician Communication Form indicated that Resident #1's Physician approved the medication change and signed and dated the form on 1/17/24. Further Review of Resident #1's MAR indicated that although there was a new order on 1/18/24 for Pradaxa 150 mg two times a day in place, his/her order for Xarelto had not been discontinued, per the Physician's orders. Review of Resident #1's MAR, dated 1/18/24 through 1/24/24, indicated he/she received the medications Xarelto 20 mg and Pradaxa 150 mg, on following dates and times: - 1/18/24 Xarelto at 9:00 A.M., (despite NP order to hold the medication) - 1/19/24 Xarelto at 9:00 A.M., (despite MD order to discontinue medication) - 1/20/24 Xarelto at 9:00 A.M., (despite MD order to discontinue medication) - 1/20/24 Pradaxa at 9:00 A.M., - 1/20/24 Pradaxa at 5:00 P.M., - 1/21/24 Xarelto at 9:00 A.M., (despite MD order to discontinue medication) - 1/21/24 Pradaxa at 9:00 A.M., - 1/21/24 Pradaxa at 5:00 P.M., - 1/22/24 Xarelto at 9:00 A.M., (despite MD order to discontinue medication) - 1/22/24 Pradaxa at 9:00 A.M., - 1/22/24 Pradaxa at 5:00 P.M., - 1/23/24 Xarelto at 9:00 A.M., (despite MD order to discontinue medication) - 1/23/24 Pradaxa at 9:00 A.M., - 1/23/24 Pradaxa at 5:00 P.M., - 1/24/24 Xarelto at 9:00 A.M., (despite MD order to discontinue medication) - 1/24/24 Pradaxa at 9:00 A.M., Although, Resident #1 was being administered two anticoagulants daily at 9:00 A.M. by nursing, there was no documentation during the above time period to support that any of the nurses questioned the need or the risks to Resident #1 of being administered both anticoagulant medications. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/08/24 at 1:27 P.M., with Nurse #1 (which included review of her written witness statement, dated 1/25/24), Nurse #1 said she worked 7:00 A.M. to 11:00 P.M. on 1/17/24 and was assigned to care for Resident #1. Nurse #1 said she received a phone call from the Oncology NP stating they wanted to change Resident #1's Xarelto to Pradaxa before he/she started chemotherapy in February. Nurse #1 said she documented the information on a MD communication form and asked Resident #1's Physician (who was in the Facility at the time) to review the form and that the Physician agreed to change Resident #1's medication and provided an order to discontinue his/her Xarelto and wrote a new order to start the Pradaxa. Nurse #1 said she entered the new order for Pradaxa into Resident #1's Electronic Medication Administration Record (EMAR) and had asked Nurse #2 to confirm and co-sign the order. Nurse #1 said she could not remember if she entered the order to hold Resident #1's Xarelto on 1/18/24 into his/her EMAR. Nurse #1 said Resident #1 ended up being administered both anticoagulant medications because she had not entered the order into the EMAR to discontinue his/her Xarelto on 1/17/24, and that she should have done so. During an interview on 4/08/24 at 2:24 P.M., Nurse #2 said she worked the 11:00 P.M. to 7:00 A.M. shift on 1/17/24, and could not remember who the 3:00 P.M. to 11:00 P.M. nurse was that night. Nurse #2 said she could not recall the details about Resident #1's medication error and said she did not want to say anything more about it. During an interview on 4/08/24 at 4:19 P.M., Nurse #4 said she worked the 7:00 A.M. to 3:00 P.M. shift on 1/18/24 and was assigned to care for Resident #1. Nurse #4 said Resident #1 had a new order for Pradaxa, but the medication was unavailable to administer to him/her because it had not been delivered from the pharmacy, so she administered Xarelto to Resident #1 as ordered. Nurse #4 said she notified the NP that the Pradaxa was not available and received an order to hold Resident #1's Pradaxa for three days until it was received from the pharmacy. Review of Resident #1's Physician Progress Note, dated 1/24/24, indicated that Resident was receiving Xarelto and Pradaxa and his/her stool was black, was guaiac tested (checks for occult, hidden blood in the stool) and the result was positive (presence of blood). The Note indicated there was a concern that Resident #1 had an active upper gastrointestinal (GI) bleed, to closely monitoring him/her, check complete blood count (CBC) with differential (measures the number of each type of white blood cells) and basic metabolic panel (BMP) stat and if his/her hemoglobin (Hgb) is less than 7.0 g/dl, he/she would need a blood transfusion. The Note further indicated Resident #1 was recently seen by Oncology for melanoma (skin cancer) with a recommendation to switch his/her Xarelto to Pradaxa, however he/she was receiving both medications over several days. The Note indicated the Physician spoke with the nursing staff about the medication error, and ordered to discontinue the Xarelto, hold Pradaxa times one week, give one dose of Protonix (treats conditions that cause to much stomach acid) 40 mg stat, then increase to Protonix to 80 mg twice a day and monitor vital signs every shift and follow up (with physician) when laboratory results become available. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/03/24 at 1:27 P.M., the Physician said on 1/17/24 Nurse #1 informed her of the recommendations received from Oncology to switch Resident #1's Xarelto to Pradaxa. The Physician said she reviewed the MD communication form with Nurse #1, agreed to the medication change and signed the form as an order. The Physician said she saw Resident #1 on 1/24/24 for nausea and vomiting, that the resident told her that his/her stool was black. The Physician said Resident #1's face looked pale, and that nursing staff had done a guaiac test with positive results for the presence of blood. The Physician said she reviewed Resident #1's medications and discovered that he/she was receiving two anticoagulants, and that the Xarelto should have been discontinued by nursing on 1/17/24 as ordered, with Resident #1 only receiving Pradaxa. The Physician said on 1/24/24 she wrote new orders to stop Resident #1's Xarelto, hold the Pradaxa times one week, check CBC and BMP stat and informed Nurse #1 that if Resident #1's Hgb is below 7.0 g/dl he/she needed to be sent to the Hospital ED for a blood transfusion. The Physician said she informed the Unit manager that she had found the medication error. During an interview on 4/08/24 at 5:09 P.M., Certified Nurse Aide (CNA) #1 said she worked on 1/23/24 and 1/24/23 from 7:00 A.M. to 2:00 P.M. and was assigned to care for Resident #1 on both days. CNA #1 said on 1/24/24 she was providing incontinent care to Resident #1, his/her stool looked bloody, and she reported what she saw to the Nurse (could not recall exact name, later identified as Nurse #1). CNA #1 said that Resident #1 did not have blood in his/her stool the day before on 1/23/24. Review of Resident #1's Laboratory Results (obtained at the Facility), dated 01/24/24, indicated his/her hemoglobin (Hgb) level was critically low at 5.3 g/dl, (normal range 12.0-16.0 g/dl). Review of Resident #1's Situation, Background, Assessment, Recommendation (SBAR) Note (written by Nurse #1), dated 1/24/24, indicated Resident #1's hemoglobin and red blood cell counts were low, lab results reported to on-call NP and an order was obtained to transfer him/her to the Hospital ED. Review of Resident #1's Hospital ED to Hospital Admission Report, dated 1/24/24, indicated that Resident #1 presented to the ED after the Facility noticed blood in his/her stool, related to a concern for GI bleeding in the context of possible over-anticoagulation with Xarelto and Pradaxa. The Report indicated Resident #1 had a low hematocrit level of 16.7 % and his/her hemoglobin level was 5.2 g/dl, was also low. The Report further indicated that Resident #1 received anticoagulation reversal with the medication Kcentra (a blood coagulation used to quickly reverse the effects of a blood-thinning medicine during a bleeding episode), he/she was transfused with two units of packed red blood cells and admitted for further treatment. During an interview on 4/03/24 at 3:24 P.M., the Director of Nurses (DON) said on 1/24/24 she was made aware of Resident #1's medication error and started an investigation. The DON said that after reviewing Resident #1's medical record she determined that he/she had been receiving two anticoagulant medications (Xarelto and Pradaxa). The DON said that on 1/17/24 Nurse #1 had received a call from Resident #1's Oncology office asking to switch his/her Xarelto to Pradaxa before starting chemotherapy and Nurse #1 obtained orders from the Physician. The DON said Nurse #1 transcribed the new order for the Pradaxa into Resident #1's EMAR but had not discontinued the order for Xarelto. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The DON said that Nurse #1 also had received an order from the NP earlier on 1/17/24 to hold Resident #1's Xarelto for one day on 1/18/24 and that Nurse #1 had not transcribed that order into Resident #1's EMAR as well. The DON said that anticoagulants are high risk medications and per facility policy, required two nurse's signatures in the EMAR system for the Physician's order to go through. The DON said Nurse #2 co-signed Resident #1's Pradaxa order on 1/17/24, but she (Nurse #2) had not checked and verified the written order before signing as the second nurse. The DON said Resident #1 received both Xarelto and Pradaxa for five days and on 1/24/24 he/she had blood in his/her stool, a stat Hgb level was drawn that showed a low level at 5.3 g/dl and Resident #1 was transferred to the Hospital ED for evaluation. The DON said Nurse #1 had not followed the Facility policy for transcribing Physician orders and her actions were not consistent with the standards of nursing practice. The DON said she expected all nurses to follow the Facility's policy and procedure for transcribing Physician medication orders. On 04/03/24, 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: A. On 1/25/24, the Director of Nurses, Assistant Director of Nurses and Unit Mangers conducted an audit on all residents receiving anticoagulant therapy, resident's Physicians were reviewed, and updated if needed to ensure correct doses were in place. B. On 1/26/24 through 1/30/24, the Staff Development Coordinator provided education to all Licensed Nursing Staff on Transcribing Physician Orders, High Risk Medications (Anticoagulants), and obtaining, transcribing, clarifying and noting Physician Orders C. On 1/29/24, Resident #1 returned to the Facility with interventions that included: medication reconciliation completed upon re-admission, monitor for signs/symptoms of anticoagulation complications, vital signs monitored every shift for seven days, and the Physician assessed, verified and reviewed medications upon return. D. All residents on anticoagulants are discussed at the weekly risk meeting and residents with new orders for anticoagulants will be reviewed at morning meeting to ensure proper administration. E. The Director of Nurses and/or designee will review all newly admitted residents records and Physician orders. F. The DON and/or designee will conduct up to ten random audits on residents receiving anticoagulants one time per week for three weeks and then two times monthly for two months. G. Findings of the audits will be reviewed at the quarterly QAPI meeting for three meetings. H. The Director of Nurses and/or designee are responsible for overall compliance.