

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Care One at Millbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was newly admitted to the facility, and whose Physician orders included administration of Teriparatide (parathyroid hormone used to treat osteoporosis) injectable pen, which required refrigeration, the facility failed to ensure nursing stored the medication in accordance with manufacturer recommendations when the medication was not refrigerated as required. Findings include: Review of the Facility's policy titled Adverse Consequences and Medication Errors, dated as revised June 2025, indicated medications are administered in a safe and timely manner, and as prescribed; - A medication error is the preparation or administration of medication which is not in accordance with manufacturer specifications. - Failure to follow manufacturers' instructions and or accepted professional standards. Review of the [NAME] Lilly and Company product information manual dated as revised 8/04/21 indicated; Refrigerate the Teriparatide pen immediately after every use. Resident #1 was admitted to the Facility in January 2026, diagnoses included Gastrointestinal bleed, Anemia, Acute Kidney Failure, Psoriatic Arthritis, and Osteoporosis. Review of Resident #1's Physician's Orders for January 2026, indicated his/her orders included Teriparatide Subcutaneous (sc) Solution Pen-Injector 560 micrograms (mcg)/2.24 milliliters (ml), inject 0.08 ml sc daily in the morning. During a telephone interview on 05/12/26 at 4:43 P.M., Family Member #1 said she had brought in Resident #1's Teriparatide pen on the morning of 02/03/26 and gave the medication to Nurse #1. Family Member #1 said on 02/06/26 Resident #1 notified her that the pen felt warm to him/her, that he/she had questioned the nurse as to where it was being stored, and that the nurse said it had been kept in the medication cart. During a telephone interview 05/18/26 at 1:47 P.M., the Facility's Pharmacist said Teriparatide (an injectable medication for osteoporosis) requires refrigeration at 36 to 46 degrees Fahrenheit, comes in a 28-day supply pen and can be left out up to 36 hours but then must be put back in the refrigerator. During an interview on 05/14/26 at 12:39 P.M., Nurse #1 said she did not read the medication instructions for storage when she received Resident #1's medication (Teriparatide) from Family Member #1 on the morning of 02/03/26. Nurse #1 said she did not refrigerate the medication and just put the medication in the medication cart. Nurse #1 said the medication was stored in the medication cart from 02/03/26 when she received it, until 02/06/26 (four days later). Nurse #1 said when she went to administer the medication, Resident #1 told her that the pen felt warm and he/she declined the medication. Resident #1's Teriparatide sc pen went unrefrigerated anywhere from 72 to 96 hours, which was not in accordance with the manufacturers' guidelines which indicated the pen needed to be refrigerated after each use, and was well beyond the parameters provided by the facility's Pharmacist. Review of the Nurse Practitioner Progress Note dated 02/08/26, indicated the facility notified the Provider that the medication Teriparatide was brought in from Resident #1's home and was not refrigerated by nursing staff for an extended period, rendering it unusable and he/she missed approximately three days of therapy. During an interview on 05/14/26 at 12:50 P.M., the Director of Nurses (DON) said when Resident #1's medication Teriparatide was brought in from (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her family member on 02/03/26, it should have been placed in the refrigerator by Nurse #1, and it was not. The DON said she was notified by Resident #1 and Family Member #1 on 02/06/26 that the medication pen felt warm to Resident #1 and he/she had declined the medication as to the medication can only be left unrefrigerated for up to 36 hours. The DON said education was provided to the Nursing staff on storing medications per the manufacturer's instruction.		