STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative and staff interviews, it has been determined that the facility failed to immediately consult with the resident's physician and inform the resident's representative when there was a need to commence a new form of treatment to deal with a problem for 1 of 1 resident reviewed who was administered medications in error, Resident ID #1. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health (RIDOH) on 6/19/2025 revealed that Resident ID #1 went home on a leave of absence (LOA) on 6/15/2025 and the facility was notified that the resident was sent emergently to an acute care hospital by the family. Furthermore, the report indicates that it was discovered that the resident had received 200 mg [milligrams] of Clozapine [Clozaril- a medication prescribed to treat major psychiatric diagnoses like schizophrenia] in error. Additional review of this facility reported incident revealed a note from the RIDOH triage nurse, that a phone call was placed to the facility upon receipt of this incident for clarification purposes where the administrator revealed that the resident had received this medication by a nurse in the facility and not from any family member during his/her LOA on 6/15/2025. Record review revealed the resident was admitted to the facility in April of 2025 with diagnoses including, but not limited to, type 2 diabetes mellitus, dementia, bradycardia (low heart rate), nonrheumatic aortic valve stenosis (heart condition that makes it harder for blood to flow out of the heart to the rest of the body). Record review of a Quarterly Minimum Data Set assessment dated [DATE], revealed the resident is . rarely/never understood . Additionally, the assessment revealed that the resident has short and long-term memory problems. Further review revealed his/her cognitive skills for daily decision making is severely impaired. Record review of an undated written statement authored by Registered Nurse (RN), Staff A, revealed that on the morning of 6/15/2025 she administered another resident's (Resident ID #2) antipsychotic medications to Resident ID #1 at approximately 8:30 AM. Additionally, the statement revealed that a staff member familiar with the residents identified the medication errors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview with Licensed Practical Nurse, Staff B, on 6/23/2025 at 11:42 AM, she revealed that she and Staff A were the two nurses assigned to work on Resident ID #1's unit on 6/15/2025. Additionally, Staff B revealed that she was the nurse that was assigned to care for Resident ID #1 on that date. She revealed that she observed Staff A standing over Resident ID #1 as if she was administering medications to him/her. Staff B then questioned Staff A about what was administered to the resident and Staff A replied she administered all the medications that were highlighted red on the screen (medications that are highlighted as red, indicate they are late for their scheduled administration time) were administered. Furthermore, she revealed that Staff A had administered another resident's medications, Resident ID #2, to Resident ID #1. Record review of Resident ID #2s June 2025 Medication Administration Record revealed that Staff A documented the following medications as being administered at 9:47 AM on 6/15/2025: - Clozaril - 200 mg - Geodon (antipsychotic medication) 80 mg This indicates that Resident ID #1 was administered two significant antipsychotic medications in error. A surveyor telephone interview with Staff A was attempted on 6/23/2025 at 10:33 AM and 6/25/2025 at 10:57 AM, however, she did not answer and has not returned the surveyor's calls. Additionally, during the surveyor interview with Staff B, on 6/23/2025 at 11:42 AM she revealed that she saw Resident ID #1's spouse in the facility visiting with him/her after the medication errors had been made. Additionally, she revealed that she did not inform the spouse of the medication errors because she was waiting to speak with a provider first. During a surveyor interview on 6/23/2025 at approximately 11:00 AM, with the resident's spouse and one of their children, in the presence of Resident ID #1, The spouse indicated that s/he arrived at the facility at approximately 10:00 AM on 6/15/2025 and took the resident out of the facility on a LOA at 11:00 AM to go to their child's home, who lives nearby the facility. Furthermore, s/he revealed that when they arrived at their child's home the resident immediately became unresponsive, and s/he called 911. Lastly, the resident's spouse revealed that although s/he had been in the facility visiting with the resident for approximately an hour prior to taking him/her out on an LOA, none of the facility's staff had informed him/her that the resident had received the incorrect medications that morning. S/he indicated that if s/he knew the resident received someone else's medications, s/he would have never have taken the resident out of the facility. Lastly, they revealed they were not made aware of the medication error until they presented back to the facility to acquire a copy of the resident's advance directive to provide to Emergency Medical Services (EMS). Furthermore, during the surveyor interview with Staff B, on 6/23/2025 at 11:42 AM she revealed that she did not call the resident's provider to inform them of the medication error that had occurred until after the resident's family presented to the facility to obtain documentation from the facility for EMS transport to the hospital. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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 0580 Level of Harm - Actual harm Residents Affected - Few	The surveyor interview with Staff B, on 6/23/2025 at 11:42 indicates that the facility failed to immediately consult with the resident's physician and inform the resident's representative when there was a need to commence a new form of treatment to deal with the medication error. During a surveyor interview with the Director of Nursing Services in the presence of the Administrator on 6/23/2025 at 1:35 PM, they were unable to provide evidence that the facility immediately consulted with the resident's physician and informed the resident's representative when there was a need to commence a new form of treatment to deal with a problem for Resident ID #1. Additional record review revealed the resident required emergency medical transport, hospitalization, and ventilation assistance (ventilators are lifesaving machines that can support breathing function in the body when diagnosed with critical health conditions) because s/he received medications that were not prescribed for him/her. Cross reference F684 and F760

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and resident representative and staff interviews, it has been determined that the facility failed to provide treatment and care in accordance with professional standards of practice, as because the facility failed to monitor a resident for side effects after s/he was administered significant antipsychotic medications in error, nursing failed to inform additional staff on the unit that an error had occurred in order to enable all staff to assist in the monitoring of the resident, the failure to notify a provider of the medication error timely, the failure to inform the resident's family of the error at all, and allowed a resident who required monitoring to leave the facility on a leave of absence (LOA), for 1 of 1 resident reviewed who required emergency medical transport, hospitalization, and ventilation (ventilators are lifesaving machines that can support breathing function in the body when diagnosed with critical health conditions), Resident ID #1. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health (RIDOH) on 6/19/2025 revealed that Resident ID #1 went home on a leave of absence (LOA) on 6/15/2025 and the facility was notified that the resident was sent emergently to an acute care hospital by the family. Furthermore, the report indicates that it was discovered that the resident had received 200 mg [milligrams] of Clozapine [Clozaril- a medication prescribed to treat major psychiatric diagnoses like schizophrenia] in error. Additional review of this facility reported incident revealed a note from the RIDOH triage nurse, that a phone call was placed to the facility upon receipt of this incident for clarification purposes where the administrator revealed that the resident had received this medication by a nurse in the facility and not from any family member during his/her LOA on 6/15/2025. Record review of a facility policy revised on 7/1/2024 titled, Medication Errors states in part, .Appropriate interventions will be implemented. Patients [residents] involved in a medication error will be evaluated for adverse effects and their provider and responsible party will be notified . Record review revealed Resident ID #1 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, type 2 diabetes mellitus, dementia, bradycardia (low heart rate), nonrheumatic aortic valve stenosis (heart condition that makes it harder for blood to flow out of the heart to the rest of the body). Record review of a Quarterly Minimum Data Set assessment dated [DATE], revealed the resident is . rarely/never understood . Additionally, the assessment revealed that the resident has short and long-term memory problems. Further review revealed his/her cognitive skills for daily decision making is severely impaired. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Record review of an undated written statement authored by Registered Nurse, Staff A, revealed that on the morning of 6/15/2025 she administered another resident's (Resident ID #2) medications to Resident ID #1 at approximately 8:30 AM. Additionally, the statement stated that .I believe it was 200 mg of Clozapine, Calcium carbonate and a multivitamin. I was unable to identify the resident appropriately and when I had my initial encounter the resident must have misunderstood when I said [Resident ID #2's name] and thought I said [his/her name]. [Resident ID #1] ingested the medications and at that time an employee familiar with the residents identified the error .the resident remained in the dining area to ensure appropriate monitoring, vital signs were checked, and a note was documented in the system . During a surveyor interview with Licensed Practical Nurse (LPN) Staff B, on 6/23/2025 at 11:42 AM, she indicated that she was one of the two nurses assigned to work the unit on 6/15/2025 along with Staff A. Staff B, was the nurse that was assigned to care for Resident ID #1. Staff A was assigned to care for Resident ID #2. She observed Staff A standing over Resident ID #1 as if she was administering medications to the resident. Staff B then questioned Staff A about what was administered to the resident and Staff A responded that all the medications that were highlighted red on the screen (medications that are highlighted as red, indicate they are late for their scheduled administration time) were administered. Record review of Resident ID #2s June 2025 Medication Administration Record (MAR) revealed that Staff A documented the following medications as being administered at 9:47 AM on 6/15/2025: - Clozaril - 200 mg - Geodon (antipsychotic medication) 80 mg This indicates that Resident ID #1 was administered two significant antipsychotic medications in error. A surveyor telephone interview with Staff A was attempted on 6/23/2025 at 10:33 AM and 6/25/2025 at 10:57 AM, however, she did not answer and has not returned the surveyor's calls. 2. During a surveyor observation and interview on 6/23/2025 at approximately 11:00 AM, with the resident's spouse and one of their children, in the presence of Resident ID #1, revealed Resident ID #1 was wearing a name band on his/her left wrist. The resident's child stated the name band is always in place and was present on 6/15/2025 when s/he visited the resident in the hospital. The spouse indicated s/he arrived at the facility at approximately 10:00 AM on 6/15/2025. When the spouse arrived at the facility the resident was asleep in his/her wheelchair in the dayroom. Additionally, the spouse revealed that s/he brought the resident to his/her room to watch church on television then signed him/her out at 11:00 AM to go to their child's home, who lives close to the facility. Furthermore, s/he revealed that when they arrived at their child's home the resident immediately became unresponsive and 911 was called. Lastly, the resident's spouse revealed that although s/he had been in the facility visiting with the resident for approximately an hour prior to taking him/her out on a LOA, none of the facility's staff had informed him/her that the resident had received the incorrect medications that morning and indicated if s/he was told then s/he would have never taken the resident out of the facility. (continued on next page)

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Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This interview indicates that the resident's spouse was not informed of the resident's medication error prior, while s/he remained in the facility with the resident for approximately one hour while s/he was in the facility visiting, prior to him/her taking the resident out for a LOA. During the surveyor interview with Staff B, on 6/23/2025 at 11:42 AM, she indicated that she did see the resident's spouse in the facility visiting the resident after the medication errors had been made. Additionally, she revealed that she did not inform him/her of the medication errors because she was waiting to speak with a provider first. Furthermore, she revealed that she did not call the resident's provider to inform them of the medication error that had occurred until after the resident's family presented to the facility to obtain documentation from the facility for the Emergency Medical Services (EMS) transport. 3. During the surveyor interview with Staff B, on 6/23/2025 at 11:42 AM, she indicated that she left the unit at some point to respond to an emergency after Resident ID #1 was administered medications in error. She further revealed that she did not obtain the resident's vitals, indicated that Staff A told her she did. Record review of a Summary for Providers progress note created on 6/15/2025 at 1:49 PM, authored by Weekend Supervisor, LPN Staff C, revealed vital signs that were documented in the progress note were taken in May of 2025 and not taken in real time. During a surveyor telephone interview on 6/25/2025 at 2:30 PM, with Staff C, she revealed that she was the weekend supervisor on 6/15/2025 during the hours of 7:00 AM - 7:00 PM. Additionally, she indicated that she was notified that Staff A had administered medications in error to Resident ID #1 during the morning medication pass, after the resident was already out of the facility on a LOA with his/her family and enroute to the hospital. She further indicated that she documented the above-mentioned Summary for Providers note and acknowledged that the vital signs were from May of 2025. Staff C further stated the vital signs auto populate from the electronic medical record and indicated that she did not assess Resident ID #1 because s/he was already out of the facility at the time the progress note was created by her. 4. Additional record review revealed the on-call Nurse Practitioner's (NP) progress note dated 6/15/2025 at 8:02 PM, which states in part, .Per nursing, patient inadvertently received 200mg clozaril and 1 Tums [calcium carbonate] at 10am that was meant for another patient. According to nursing, the [spouse] then 'took [the patient] out of facility and brought [him/her] home.' Nursing was notified by patient's [spouse] that [s/he] had called EMS [Emergency Medical Services] while at home due patient's 'increased lethargy' and [s/he] was transferred to the hospital for further evaluation. Nursing states that the [spouse] took patient from the facility without notifying any staff or signing patient out .Call back on-call if/when patient returns to facility . This indicates that the on-call NP was not informed that the resident received the medications in error until approximately 9 hours after the incident occurred and the resident had already been emergently transported to the hospital via EMS. Additionally this note indicates that she was not informed that the resident also received Geodon 80 mg in error. 5. During the surveyor interview with Staff B, on 6/23/2025 at 11:42 AM, she revealed that the facility was unaware that the resident left the facility until the family returned to the facility to request paperwork for the EMS transport. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a surveyor interview on 6/23/2025 at 11:15 AM, with RN Staff D she indicated that the LOA Book, which contains sign out sheets for residents leaving the facility for LOA, is kept at the nurse's station. During a surveyor interview on 6/24/2025 at 1:26 PM, with Nursing Assistant (NA) Staff E, she indicated that she was one of the NAs assigned to work on Resident ID #1's unit on 6/15/2025 during the 7:00 AM - 3:00 PM shift. Additionally, she revealed that she was not informed by the nurses that the resident had received medications in error or that s/he should remain in the facility for monitoring. This indicates that neither Staff A or Staff B, attempted to assess the resident because if they had, they would have been aware of his/her absence prior to the resident's family presenting to the facility for paperwork to provide to EMS, or that either of them informed the other employees working on the unit of the medication errors so that they could have assisted in the monitoring of Resident ID #1 for any adverse effects s/he may have experienced as result of the medications s/he had received in error. Additionally, during the surveyor interview on 6/24/2025 at 1:26 PM, with Staff E, she indicated that she was one of the NAs assigned to work the unit on 6/15/2025 during the 7:00 AM - 3:00 PM shift. Additionally, she indicated that she had provided the resident's spouse with the LOA Book to sign Resident ID #1 out of the facility. Record review of the document titled, LEAVE OF ABSENCE FORM, in the LOA Book revealed that the resident was signed out by his/her spouse on 6/15/2025 at 11:00 AM. This indicates that from the time the resident received the medications in error, until s/he left the faciity on an LOA at approximately 11:00 AM (for more than 2 hours), Staff B, the nurse assigned to care for Resident ID #1, failed to monitor Resident ID #1 for any adverse effects from the medications that were not prescribed to him/her. Furthermore, Per Staff E's interview, the staff working on the unit were not made aware of the error, so they were unaware that the resident required enhanced monitoring for adverse effects of the medications. Additionally, this would also indicate that although the resident's spouse followed protocol and requested the LOA book from a staff member and signed out the resident as required, Staff B did not review the LOA book, indicating she was not actively trying to locate the whereabouts of her resident that experienced a significant medication error for monitoring. During a surveyor interview with the Medical Director on 6/23/2025 at 2:03 PM, he indicated that the resident should not have been allowed to leave the facility on LOA but should have remained in the facility for monitoring. Further record review failed to reveal evidence that any interventions were implemented after the resident was administered the medications intended for a different resident. Additionally, the record failed to reveal evidence that Resident ID #1 was monitored in real time for adverse effects in the hours immediately following the time the medication errors were made as s/he was permitted to leave the facility on an LOA with his/her spouse who was unaware that an error had occurred. Lastly, the record failed to reveal evidence that the provider was informed of the medication errors prior to the resident leaving the facility with his/her spouse, becoming unresponsive and being transferred to the hospital. (continued on next page)

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Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a surveyor interview with the Director of Nursing Services in the presence of the Administrator on 6/23/2025 at 1:35 PM, he acknowledged that Staff A failed to properly identify Resident ID #1 although s/he was wearing a name band. Additionally, he revealed that he would have expected Staff A to properly identify Resident ID #1 by his/her name band and administer the correct medications to the correct resident. Lastly, he revealed that he was unaware that the resident was administered Geodon in addition to the other medications, until it was brought to his attention by the surveyor. Lastly, he acknowledged that Staff A did document that she administered the Geodon to the resident at the same time as the other medications. Although Staff A's statement indicated that the resident remained in the dining area to ensure appropriate monitoring, the vital signs and note she documented in the resident's record were not entered until the day following the incident. Additionally, per the surveyor interview with the resident's spouse, the resident was found sleeping and unattended in the day room. The spouse remained in the facility for approximately one hour and s/he did not observe staff assessing the resident. The resident was signed out and then left the faciity on an LOA with his/her spouse, who had not been informed of the medication error that had been made hours prior, even though, per Staff B's interview, the facility was aware s/he was there. Moreover, per Staff E's interview, she had not been informed that an error had occurred and was unaware that the resident required any enhanced monitoring for adverse effects and provided the resident's spouse with the LOA book. Furthermore, Staff B revealed during her interview that she was unaware that the resident had left the faciity on an LOA. Lastly, record review revealed that the vital signs that were documented regarding this incident by RN, Staff A, were not entered into the record until 6/16/2025, the day after the incident occurred and while the resident was in the hospital and the vital signs that were entered on the Summary for Providers progress note were from May of 2025. As a result of this survey, it has been determined that Resident ID #1 was at risk for serious harm, injury, impairment or death due to Staff A's failure to administer medications according to the facility's policy, when she prepared and administered the medications. Resident ID #1 was administered medications intended for Resident ID #2 which resulted in Resident ID #1 exhibiting adverse effects caused by Clozaril and Geodon, which resulted in Resident ID #1 to be transferred and admitted to a hospital, where s/he required ventilation and treatment for toxic metabolic encephalopathy (a condition that disrupts normal brain function). Cross reference F580 and F760

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and resident representative and staff interview, it has been determined that the facility failed to ensure that residents are free from significant medication errors for 1 of 1 resident reviewed who was administered psychiatric medications that were prescribed for another resident, who required emergency medical transport, hospitalization, and ventilation. Medical ventilators are lifesaving machines that can support breathing function in the body when diagnosed with critical health conditions. These intervention were necessary as a result of medication errors involving Resident ID #1. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health (RIDOH) on 6/19/2025 revealed that Resident ID #1 went home on a leave of absence (LOA) on 6/15/2025 and the facility was notified that the resident was sent emergently to an acute care hospital by the family. Furthermore, the report indicates that it was discovered that the resident had received 200 mg [milligrams] of Clozapine [Clozaril- a medication prescribed to treat major psychiatric diagnoses like schizophrenia] in error. Additional review of this facility reported incident revealed a note from the RIDOH triage nurse, that a phone call was placed to the facility upon receipt of this incident for clarification purposes where the administrator clarified that the resident had received this medication by a nurse in the facility and not from any family member during his/her LOA on 6/15/2025. Record review of the facility policy revised on 1/1/2022 titled, General Dose Preparation and Medication Administration, states the following in part, .Prior to administration of medication, Facility staff should take all measures required by Facility policy and including, but not limited to the following .Verify each time a medication is administered that it is the correct medication, at the correct dose .for the correct resident . Identify the resident per Facility policy . Record review of the Food and Drug Administration's prescribing information for Clozaril states in part, . ORTHOSTATIC HYPOTENSION [a sudden drop in blood pressure when a person stands or changes position], WITH OR WITHOUT SYNCOPE [fainting], CAN OCCUR WITH CLOZAPINE TREATMENT . COLLAPSE CAN BE PROFOUND AND BE ACCOMPANIED BY RESPIRATORY AND/OR CARDIAC ARREST. ORTHOSTATIC HYPOTENSION IS MORE LIKELY TO OCCUR DURING INITIAL TITRATION IN ASSOCIATION WITH RAPID DOSE ESCALATION. IN PATIENTS WHO HAVE HAD EVEN A BRIEF INTERVAL OFF CLOZAPINE, i.e., 2 OR MORE DAYS SINCE THE LAST DOSE, TREATMENT SHOULD BE STARTED WITH 12.5 mg ONCE OR TWICE DAILY .ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS TREATED WITH ANTIPSYCHOTIC DRUGS ARE AT AN INCREASED RISK OF DEATH . Record review of the manufacturer's prescribing information for Geodon states the following in part, . GEODON is not approved for the treatment of patients with dementia-related psychosis. Elderly patients with a diagnosis of psychosis related to dementia treated with antipsychotics are at an increased risk for death . one potential side effect is that it may change the way the electrical current in your heart works .Your risk of dangerous changes in heart rhythm can be increased if you are taking certain other medicines and if you already have certain abnormal heart conditions . (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed Resident ID #1 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, type 2 diabetes mellitus, dementia, bradycardia (low heart rate), nonrheumatic aortic valve stenosis (heart condition that makes it harder for blood to flow out of the heart to the rest of the body). Record review of a Minimum Data Set assessment dated [DATE], revealed the resident is rarely/never understood. Additionally, the assessment revealed that the resident has short and long-term memory problems. Further review reveals his/her cognitive skills for daily decision making is severely impaired. Record review of an undated written statement authored by Registered Nurse, Staff A, revealed that on the morning of 6/15/2025 she administered another resident's (Resident ID #2) medications to Resident ID #1 at approximately 8:30 AM. Additionally, the statement stated that I believe it was 200 mg of Clozapine, Calcium carbonate and a multivitamin. I was unable to identify the resident appropriately and when I had my initial encounter the resent must have misunderstood when I said [Resident ID #2's name] and thought I said [his/her name]. [Resident ID #1] ingested the medications and at that time an employee familiar with the residents identified the error . A surveyor telephone interview with Staff A was attempted on 6/23/2025 at 10:33 AM and 6/25/2025 at 10:57 AM, however, she did not answer and has not returned the surveyor's calls. During a surveyor interview with Licensed Practical Nurse (LPN), Staff B, on 6/23/2025 at 11:42 AM, she indicated that on the morning of 6/15/2025 she was the nurse assigned to care for Resident ID #1. Additionally, Staff B indicated that she observed Staff A standing over Resident ID #1 with a medication cup in her hand as if she had just administered medications to the resident. She then questioned herself as to why, because Resident ID #1 was assigned to her and she had already administered the resident's morning medications to him/her. Additionally, she revealed that she approached Staff A and questioned if and/or what medications she had administered to Resident ID #1 and Staff A responded that all of the medications that were highlighted red on the screen (medications that are highlighted as red, indicate they are late for their scheduled administration time) were administered. Record review of Resident ID #2's June 2025 Medication Administration Record (MAR) revealed that Staff A documented the following medications in part as being administered at on 6/15/2025 9:47 AM: - Clozaril 200 mg - Geodon (an antipsychotic medication) 80 mg This indicates that Geodon, another significant antipsychotic medication, which has significant side effects, was also administered to Resident ID #1 in error. Record review of Resident ID #1's June 2025 MAR revealed s/he received the following medications on the morning of 6/15/2025: - Citalopram (an antidepressant) 40 mg - Norvasc (a medication prescribed to treat high blood pressure) 2.5 mg (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Lisinopril (a medication prescribed to treat high blood pressure) 20 mg - Gabapentin (a medication prescribed to treat nerve pain; it works by reducing the excitability of nerve cells in the brain) Additional record review for Resident ID #1 failed to reveal evidence of a physician's order for Clozaril 200 mg or Geodon 80 mg. During a surveyor observation and interview on 6/23/2025 at approximately 11:00 AM, with the resident's spouse and one of their children, in the presence of Resident ID #1, revealed Resident ID #1 was wearing a name band on his/her left wrist. The resident's child stated the name band has been on him/her and was present on the resident on 6/15/2025 when s/he visited him/her in the hospital. The spouse indicated s/he arrived at the facility at approximately 10:00 AM on 6/15/2025. When the spouse arrived at the facility s/he found the resident asleep in his/her wheelchair in the dayroom. Additionally, the spouse revealed that s/he brought the resident to his/her room and watched church services on the television, s/he then signed the resident out for an LOA at 11:00 AM to go to their child's home, who lives nearby the facility. Furthermore, s/he revealed that when they arrived at their child's home the resident immediately became unresponsive and s/he called 911. Lastly, the resident's spouse revealed that although s/he had been in the facility visiting with the resident for approximately an hour prior to taking him/her out on an LOA, none of the facility's staff had informed him/her that the resident had received the incorrect medications that morning. S/he indicated that if s/he knew the resident received someone else's medications, s/he would have never have taken the resident out of the facility. Record review of the Emergency Medical Services (EMS) Patient Care Report document dated 6/15/2025 at 11:17 AM, revealed that upon arrival the resident was found sitting in a wheelchair, slumped over, breathing, but responsive to painful stimulation only. The report further indicates that the resident's family reported that s/he was sleepy and not him/herself earlier that day while at the nursing home. S/he was placed in the ambulance and noted his/her assessment and vital signs as a shallow respiratory rate (type of breathing that that can make it harder to get enough oxygen into your lungs) at 14 breaths per minute (BPM, normal range for a healthy adult is 12 - 20). The note also revealed that the resident was placed on oxygen at 15 liters per minute via a non-rebreather mask (a medical device usually used in emergencies where someone needs a lot of oxygen quickly). Furthermore, the document revealed that the resident was transported to the hospital and reassessed every five minutes. While enroute his/her respiratory rate fell below 8 BPM, and his/her blood pressure decreased requiring intravenous fluids and ventilation (a machine or device used medically to support or replace the breathing of a person who is ill or injured). In addition, the resident's family member accompanied him/her in the ambulance and received notification from the nursing home via telephone that the resident was administered the wrong medication earlier in the day. Lastly, the document revealed the following vital signs: - 6/15/2025 11:30 AM, blood pressure 104/59 (normal is 120/80) and respirations shallow at 6 BPM - 6/15/2025 11:47 AM, blood pressure 82/26 and respirations 12 while mechanically assisted (continued on next page)

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	415078	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the hospital documentation revealed that the resident was reportedly in his/her usual state of health until at approximately 9:00 AM or 10:00 AM on 6/15/2025 s/he was erroneously given a dose of clozapine 200 mg at his/her nursing home which was intended for another resident. .Patient [resident] subsequently became acutely encephalopathic (abnormal brain function). Poison control contacted .Patient was admitted after accidentally [s/he] received an overdose 200 mg of clozapine. Additionally, the documents revealed that s/he was admitted and treated for accidental overdose of clozapine, toxic metabolic encephalopathy (a temporary brain problem caused by a harmful substance like drugs or medications). Further review failed to reveal evidence that the facility informed the hospital that the resident also received Geodon 80 mg, that was intended for a different resident. During a surveyor interview with the Medical Director on 6/23/2025 at 2:03 PM, he indicated that the resident should not have been allowed to leave the facility on LOA and should have remained in the facility to be monitored. During a surveyor interview with the Director of Nursing Services in the presence of the Administrator on 6/23/2025 at 1:35 PM, he acknowledged that Staff A failed to properly identify Resident ID #1 although s/he was wearing a name band, which resulted in the significant mediation errors. Additionally, he acknowledged that he would have expected Staff A to properly identify Resident ID #1 and administer the correct medications to the correct resident. Lastly, he revealed that he was unaware that the resident was administered Geodon erroneously as well and acknowledged that Staff A documented the Geodon as administered at the same time as the clozapine was administered, until it was brought to his attention by the surveyor. As a result of this survey, it has been determined that Resident ID #1 was at risk for serious harm, injury, impairment or death due to Staff A's failure to administer medications according to the facility's policy, when she prepared and administered the medications. Resident ID #1 was administered medications intended for Resident ID #2 which resulted in Resident ID #1 exhibited adverse effects caused by Clozaril and Geodon, which resulted in Resident ID #1 to be transferred and admitted to a hospital, where s/he required ventilation and treatment for toxic metabolic encephalopathy. Cross reference F580 and F684