| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415097 | A. Building<br>B. Wing | 06/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mansion Nursing and Rehab Center | 104 Clay Street<br>Central Falls, RI 02863 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on clinical record review and staff interview, the facility failed to ensure residents were free from significant medication errors for 1 of 1 resident reviewed. Resident ID #1 was inadvertently administered multiple medications by the nurse assigned to Resident ID #1's roommate, Resident ID #2. The medications included, an insulin injection, two antipsychotics, an antidiabetic, a benzodiazepine, an anticonvulsant, two antidepressants, a laxative, and eye drops. Additionally, Resident ID #1 was previously administered his/her prescribed morning medications from the Medication Aide prior to mistakenly receiving his/her roommate's medications. As a result of the errors, Resident ID #1 became unresponsive and hypoglycemic (a condition that occurs when your blood sugar level drops below a healthy range) and required hospitalization. Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 5/26/2026, indicated that Resident ID #1 was inadvertently administered medications intended for another resident and s/he was subsequently transferred to the hospital where s/he was admitted . According to the policy titled, General Dose Preparation and Medication Administration, states in part, .3. Prior to administration of medication, facility staff should take all measures required.including but not limited to the following: 3.1 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.5. During medication administration, facility staff should take all measures required.including, but not limited to the following: 5.1 Verify resident identification per facility policy (e.g., picture.name).Record review revealed Resident ID #1 was re-admitted to the facility in January of 2026 with diagnoses including, but not limited to, Alzheimer's Disease, dementia, and type 2 diabetes mellitus (a metabolic condition when the body can't use insulin correctly and sugar builds up in the blood).Record review revealed that Resident ID #2 was re-admitted to the facility in November of 2024 with diagnoses including, but not limited to, type 2 diabetes mellitus with hyperglycemia (a condition that occurs when a person's blood sugar elevates to potentially dangerous levels), schizoaffective disorder, bipolar type (a chronic mental health condition combining the symptoms of schizophrenia such as false beliefs and seeing and hearing things that are not real with extreme mood swings characteristics of bipolar disorder), hypertensive heart disease without heart failure (thickening of the heart muscle due to uncontrolled high blood pressure), and other seizure disorders. During a surveyor interview on 5/27/2026 at 1:40 PM with Registered Nurse (RN), Staff A, she revealed that on 5/25/2026 she was assigned to work at the facility as an agency nurse, and that it was her first time working there in years. Staff A revealed that she received her assignment for the residents that she would be administering medications to. She indicated that she was assigned to administer medications to Resident ID #2 and not to Resident ID #1. Staff A explained that she prepared Resident ID #2's medications at the medication cart by reviewing each of the resident's medications, the resident's name with his/her profile picture in the electronic medical record and that she also observed both Resident ID #1 and ID #2's name on their room door before entering the room. Staff A indicated that at approximately 10:00 AM, once in the residents' room, she administered the medications intended for Resident ID #2 to Resident ID #1. At approximately 11:00 AM Staff A was informed by another nurse that she was monitoring Resident ID #1 due to lethargy (decrease in<br>(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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | consciousness). At approximately 12:00 PM Staff A observed Resident ID #1 and that is when she realized she had mistakenly administered all Resident ID #2's medications to Resident ID #1, in error. Staff A indicated she assessed Resident ID #1 and s/he was unresponsive and had a blood sugar reading of 61 (a normal blood glucose level is 70-99). The physician was notified of the change in the resident's condition and ordered a Glucagon (a medication prescribed to raise blood sugar levels) injection, which was administered to the resident. Emergency Medical Services (EMS) was called and transferred the resident to the hospital for an evaluation. Additionally, Staff A acknowledged that she administered the following medications in error to Resident ID #1, which were intended for Resident ID #2:-Insulin Glargine 14 units (an antidiabetic)-Losartan 75 milligram (mg) (antihypertensive)-Aripiprazole 20 mg (antipsychotic)-Ativan 1 mg (benzodiazepine)-Brivaracetam 50 mg (antiseizure) -Clozaril 100 mg (antipsychotic)-Glipizide 20 mg (antidiabetic)-Miralax 17 grams (laxative)-Prednisolone 1% eye drops-Sertraline 100 mg (antidepressant)-Trazodone 75 mg (antidepressant)During a surveyor interview on 5/27/2026 at 2:34 PM with Medication Aide (MA), Staff B, she revealed that on 5/25/2026 she was assigned to work at the facility as an agency MA and that this was her first time at this facility. Staff B further revealed that she was assigned to administer medications to Resident ID #1 and indicated that she had administered all his/her morning medications between 8:00-8:30 AM. Additionally, Staff B acknowledged that she administered the following medications to Resident ID #1:-Olanzapine 2.5 mg (antipsychotic)-Duloxetine 60 mg (antidepressant) -Trazodone 75 mg (antidepressant)-Guanfacine 1 mg (antihypertensive)-Losartan 75 mg (antihypertensive)-Metformin 500 mg (antidiabetic)-Aspirin 81 mg chew (antiplatelet)-Senna 8.6 mg (laxative) -Miralax 17 grams (laxative)Record review of the EMS Prehospital Patient Care Report, dated 5/25/2026, revealed that upon arrival to the facility the resident was breathing but unresponsive, pale, and s/he was responding to physical stimuli with incomprehensible sounds. Vital signs (VS) from the facility staff given to EMS were as follows; blood pressure (BP) 78/57 (a normal blood pressure reading is 120/80), heart rate (HR) 49 (a normal heart rate reading is 60-100), respiratory rate (RR) 17 (a normal respiratory rate reading is 16-25) and his/her blood sugar was last noted as 64. The EMS staff administered intravenous (IV) fluids and reassessed the resident and his/her VS were as follows; BP 111/86, HR 47, RR 15 and his/her oxygen saturation level was 98% (normal level is 95-100). EMS then transferred the resident to the hospital for further evaluation. Record review of the hospital continuity of care document, dated 5/25/2026, revealed that Resident ID #1 arrived at the Emergency Department (ED) after being transported by EMS at approximately 2:15 PM, presenting obtunded (a state of reduced consciousness or alertness, typically requiring more than normal efforts to wake) but responsive to strong verbal and tactile stimulation. Due to the resident receiving his/her roommate's medications, as well as his/her own medications, the hospital's plan was to admit the resident and obtain hourly monitoring of the resident's blood sugars, continuous cardiopulmonary (heart and lungs) monitoring, EKG (electrical activity of the heart) monitoring, capnography (continuous monitoring of carbon dioxide levels to monitor the resident's ventilation ((movement of air in and out of the lungs)), metabolism ((chemical reactions within the body that sustain life)), and circulation ((continuous movement of blood throughout the body))), monitoring, and to obtain an chest x-ray. At approximately 3:00 PM laboratory findings indicated a pH venous level (measure of the acidity or alkalinity in the blood) of 7.24 (normal levels 7.31 to 7.41) and a pCO2 venous level (measure of the pressure of carbon dioxide gas dissolved in the blood as it travels back from the body's tissues to the lungs) of 66 (normal levels 35-45), indicating partially compensated respiratory acidosis (a condition where the lungs fail to adequately eliminate carbon dioxide). The record further indicated that at 5:30 PM, the resident's blood glucose reading was now 36 and required the administration of an amp of D50 (an IV solution of dextrose in water for rapid treatment of low blood sugar). Lastly the record stated .Hypoglycemia to 36 in the setting of Glargine and Glipizide consumption with concern for continued hypoglycemia giving [sic] long-acting effects of these medications . The resident's Metformin was held, and new physician's orders for medications<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | were given in the event s/he had an additional episode of hypoglycemia.During a surveyor interview on 5/29/2026 at approximately 3:30 PM with the Director of Nursing Services, she acknowledged that Resident ID #1 inadvertently received Resident ID #2's medications on 5/25/2026, and that Resident ID #1 become unresponsive, with a blood glucose level of 61 and was given Glucagon. Additionally, the resident was subsequently transferred to the hospital and was admitted .As a result of the facility's failure to ensure medications were administered to the correct resident in accordance with facility policy, Resident ID #1 received multiple medications intended for another resident, despite having already received his/her own scheduled morning medications. Specifically, the facility failed to verify resident identity prior to medication administration, resulting in Resident ID #1 receiving an additional antidiabetic, antihypertensive, antipsychotic, antidepressant, antiseizure medication, benzodiazepine, and other medications prescribed for Resident ID #2.Consequently, Resident ID #1 experienced a significant decline in condition, becoming lethargic, unresponsive, hypoglycemic, hypotensive (low blood pressure), and bradycardic (low heart rate), requiring the administration of an emergency medication, emergency medical services transport, hospitalization, continuous cardiac and respiratory monitoring, and treatment for severe hypoglycemia and respiratory acidosis. This deficient practice had the potential to cause serious injury, impairment, or death and resulted in actual harm to Resident ID #1. |