STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415099	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Lake Rehabilitation and Care Center	999 South Main Street Pascoag, RI 02859

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43987 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from significant medication errors for 1 of 2 residents reviewed for the transcription of admissions orders, Resident ID #1. Findings are as follows: 1) Record review revealed the resident was initially admitted to the facility in January of 2015 with diagnoses including, but not limited to, seizures and anxiety disorder. Record review of a nursing progress note dated 9/11/2024 at 1:41 PM revealed that the resident presented with seizure activity that lasted for approximately seven minutes. The resident was transported to the hospital. Further review revealed the resident was admitted to the hospital on 9/11/2024 with diagnoses including but not limited to; seizure, urinary tract infection (UTI), community acquired pneumonia, and acute hypoxic respiratory failure. The resident was discharged from the hospital on 9/13/2024 and readmitted back to the facility. Record review of a progress note dated 9/14/2024 at 1:13 AM, authored by Registered Nurse (RN), Staff A, revealed that the resident was readmitted to the facility at the beginning of the second shift at approximately 3:00 PM on 9/13/2024. The resident arrived lethargic and was not responsive to verbal stimuli. The resident was arousable with a sternal rub. New order for STAT (immediate) labs obtained due to resident's condition. Record review of the hospital continuity of care form date 9/13/2024 revealed the following medication orders: - Keppra (an anticonvulsant medication prescribed to treat seizures) 1000 milligrams two times daily - Aripiprazole (a medication prescribed to treat depression) 10 mg daily - Aspirin 81 mg once daily - Cefdinir (an antibiotic) 300 mg two times daily for five days (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	- Cholecalciferol 1.25 mg daily - Gabapentin (a medication prescribed to treat and prevent seizures) 600 mg three times daily - Lactulose (a medication prescribed to reduce the amount of ammonia in the blood) 20 grams three times daily - Levothyroxine (a medication prescribed to treat hypothyroidism) 75 micrograms (mcg) once a day on Saturdays and Sundays before breakfast - Levothyroxine 50 mcg daily Monday through Friday before breakfast - Lipitor- 40 mg daily at hour of sleep - Ativan (an antianxiety medication which also can be used to control seizures)1 mg two times daily - Topamax (a medication prescribed to treat and prevent seizures) 200 mg twice daily - Trazodone (a medication prescribed for sleep) 50 mg at hour of sleep - Venlafaxine (a medication prescribed to treat depression) 225 mg daily in the morning with breakfast - Venlafaxine (a medication prescribed to treat depression) 75 mg daily at hour of sleep Record review of the September 2024 Medication Administration Record (MAR) failed to reveal evidence that the resident received the above-mentioned medications on the following dates and times: Keppra - 9/13/2024 - PM dose 9/14/2024- AM dose Ativan - 9/13/2024- PM dose 9/14/2024- AM dose Aripiprazole 9/14/2024- AM dose Cholecalciferol 9/14/2024- AM dose (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Aspirin- 9/14/2024- AM dose Gabapentin 9/13/2024- afternoon and PM doses 9/14/2024- AM dose Lactulose- 9/13/2024- PM dose 9/14/2024 - AM and afternoon dose Cefdinir- 9/13/2024- PM dose 9/14/2024- AM dose Levothyroxine - 9/14/2024-AM dose Lipitor - 9/13/2024-PM dose Topamax - 9/13/2024-PM dose 9/14/2024-AM dose Trazodone- 9/13/2024- PM dose Venlafaxine- 9/13/2024- PM dose 9/14/2024- AM dose (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Additional record review revealed a progress note dated 9/14/2024 at 1:40 PM, authored by Licensed Practical Nurse (LPN), Staff B, revealed that the resident's medications were not transcribed into the electronic medication record. The Nurse Practitioner (NP), Staff H, was aware and new orders were received for Keppra 1000 mg STAT, Ativan 1mg STAT, Topamax 200 mg STAT, Abilify 10 mg STAT, Aspirin 81 mg STAT and Gabapentin 600 mg STAT. Record review of the September 2024 MAR revealed the resident received the STAT medications at approximately 1:45 PM on 9/14/2024. This indicates that this resident did not receive any medications including his/her anti-seizure medications from 3:00 PM on 9/13/2024 until approximately 1:45 PM on 9/14/2024. Further record review revealed a progress note dated 9/14/2024 at 4:05 PM, authored by LPN Staff B, that the resident presented with seizure like activity and convulsions. The first episode lasted approximately 4 minutes and the resident then experienced a second seizure. After the second episode, Staff B called the NP on call, Staff I, and received an order to send the resident out to the hospital via 911. Record review revealed the resident was admitted to the hospital on 9/14/2024 with diagnoses of seizure and acute respiratory failure with hypoxia. During a surveyor interview on 9/23/2024 at 3:54 PM with NP, Staff H she revealed that on 9/14/2024 at approximately 1:30 PM she was reviewing Resident ID #1's admission from home, and she noticed that there were no medications scheduled for the resident and contacted the facility for clarification. Staff H spoke with Staff B, who was working in the facility at that time. Staff B confirmed Resident ID #1 was in the facility and revealed that his/her admission was never completed, which is why s/he had no medication orders. NP, Staff H then gave Staff B STAT orders to administer Keppra, Ativan, Topamax, Abilify, Aspirin and Gabapentin. Staff H acknowledged that the resident should have received all his/her medications listed on the hospital discharge paperwork as long as s/he was alert. She also acknowledged that this resident did not receive any of his/her medications on the evening of 9/13/2024 and the morning of 9/14/2024 and experienced seizure like activity and was sent to the hospital for evaluation on 9/14/2024. During a surveyor interview on 9/17/2024 at 1:45 PM with the Director of Nursing Services (DNS), she revealed that there is a protocol for the admission/readmission process which is included in every admission binder. Additionally, she was unable to provide evidence of an admission binder for Resident ID #1. Record review of a written statement authored by RN, Staff A dated 9/14/2024, indicates that she was behind on her nursing tasks on the evening shift of 9/14/2024 and the NP was in the building and two admissions were expected. She expressed her concerns to the DNS. The DNS told her that she would complete the admission orders, head to toe assessments, skin checks, and vital signs for both admissions. During a surveyor interview on 9/18/2024 at 12:19 PM with Staff A, she revealed that she was the nurse that worked the 3:00 PM to 11:00 PM shift on 9/13/2024, and acknowledged that she did not complete Resident ID #1's admissions to the facility as she was told by the DNS that the DNS was going to complete the admission for Resident ID #1. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During a subsequent interview with the DNS on 9/23/2024 at 4:15 PM, she indicated that she did not complete the admission for Resident ID #1. She acknowledged that Resident ID #1 did not receive any of his/her medications including his/her anti-seizure medications on the evening of 9/13/2024 or the morning of 9/14/2024, and the resident was sent to the hospital for evaluation on 9/14/2024. 2) Record review revealed Resident ID #1 was readmitted to the facility on [DATE], from the hospital. Record review of the hospital paperwork indicates the resident is being treated for a UTI with an order for Cefdinir 300 mg capsules. Take 1 capsule by mouth two times a day, for 3 days. Record review failed to reveal evidence that the resident received the Cefdinir on 9/16/2024 during the 3:00 PM to 11:00 PM shift. During a surveyor interview on 9/18/2024 at 10:33 AM with RN, Staff G she revealed that she was the primary nurse on the 3:00 PM to 11:00 PM shift on 9/16/2024. She acknowledged that the resident did not receive the evening dose of the Cefdinir on 9/16/2024 as the DNS told her to change the start date to 9/17/2024. During an interview with the DNS on 9/23/2024 at 4:15 PM she indicated that she did not tell Staff G to change the administration date to 9/17/2024.