

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Tockwotton on the Waterfront		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Waterfront Drive East Providence, RI 02914	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>43987</p> <p>Based on record review and staff interview, it has been determined that the facility failed to follow a physician's order relative to a significant change in condition for 1 of 1 resident reviewed whom experienced bradycardia (a low heart rate), Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 2/24/2025 revealed that Resident ID #1 received an overdose of Metoprolol (a medication prescribed for high blood pressure and to control heart rate) and was admitted to the hospital after receiving a dose of 62.5 milligrams (mg), instead of his/her prescribed dose of 37.5 mg on 2/23/2025.</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing page 314, states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients.</p> <p>Record review revealed the resident was admitted to the facility in November of 2024 with diagnoses including, but not limited to, congestive heart failure (when the heart loses the ability to properly pump the blood), high blood pressure, and atrial fibrillation (extremely fast and irregular heart beat).</p> <p>Review of a progress note dated 1/17/2025 authored by Registered Nurse (RN), Staff A, states in part, Called on call [provider] for PT [patient] low HR [heart rate] and high BP [blood pressure] new orders - Hold Metoprolol reassessment on 1/21 .</p> <p>Record review failed to reveal evidence that the resident was reassessed as ordered on 1/21/2025.</p> <p>During a surveyor interview with the Director of Nursing Services on 2/25/2025 at approximately 1:30 PM, she acknowledged that Resident ID #1 had a low HR and high BP on 1/17/2025 and was to be reassessed on 1/21/2025 per the physician's order. Additionally, she was unable to provide evidence ordered assessment occurred on 1/21/2025, as ordered.</p> <p>Cross reference F 760</p>

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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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>43987</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 1 resident reviewed, Resident ID #1 relative to Metoprolol use (a medication prescribed to treat high blood pressure and to control heart rate), resulting in hospitalization due to extremely low heart rate from an overdose of Metoprolol which caused bradycardia ((a severely low heart rate) that can deprive the brain and other organs of oxygen in the body from the reduced blood circulation).</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 2/24/2025 revealed that Resident ID #1 received an overdose of Metoprolol and was admitted to the hospital due to cardiac concerns after receiving a dose of 62.5 milligrams (mg), instead of his/her prescribed dose of 37.5 mg on 2/23/2025.</p> <p>Review of a facility policy titled, Administering Medications last revised in April of 2019 states in part, . Medications are administered .as prescribed .The individual administering the medication checks the label THREE (3) times to verify the .right dose .before giving the medication .</p> <p>Review of a facility policy titled, Adverse Consequence and Medication Errors last revised in February of 2023 states in part, .A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders .Examples of medication errors include .Wrong dose .A significant medication-related error is defined as .Requiring hospitalization .</p> <p>Record review revealed the resident was admitted in November of 2024 to the facility with diagnoses including, but not limited to, congestive heart failure (when the heart loses the ability to properly pump the blood), high blood pressure, and atrial fibrillation (extremely fast and irregular heart beat).</p> <p>Review of a hospital admission document dated 2/23/2025 revealed that Resident ID #1 was transferred to the hospital after being given 62.5 mg of Metoprolol instead of his/her prescribed dose of 37.5 mg which resulted in an abnormal heart rhythm and an abnormally low heart rate (HR; normal resting heart rate for adults is between 60 and 100 beats per minute [BPM]). The document revealed that the Poison Control Center was contacted and recommended that the resident's heart rhythm and other vital signs should continuously be monitored due to the long-acting formulation of the medication.</p> <p>Record review revealed the following progress notes:</p> <p>- 2/21/2025: a nursing note authored by Registered Nurse, Staff B, indicating that the resident had a HR of 44 and new orders were obtained to decrease his/her current dose of Metoprolol and start 37.5 mg daily.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- 2/23/2025: a nursing note authored by Registered Nurse, Staff B, revealed that at approximately 11:30 AM, Certified Medication Technician (CMT), Staff C, indicated that she gave the resident 62.5 mg of Metoprolol instead of his/her prescribed dose of 37.5 mg. The provider was notified and gave new orders to discontinue Metoprolol, initiate vital signs monitoring every 2 hours, and obtain a STAT (immediate) electrocardiogram (EKG; a test that records the electrical signals of the heart). The resident was subsequently transferred to the hospital for evaluation due to his/her abnormally low HR of 37 and abnormal EKG results.</p> <p>During a surveyor interview on 2/25/2025 at 9:40 AM with CMT, Staff C, she revealed that she was aware that the resident's Metoprolol dose was changed and acknowledged that prior to administering the resident's Metoprolol on 2/23/2025, she did not reference the resident's orders or the medication label.</p> <p>During a surveyor interview with the Director of Nursing Services on 2/25/2025 at approximately 2:00 PM, she revealed that the CMT did not properly follow the facility's medication administration protocol. Additionally, the DNS acknowledged that Resident ID #1 received an incorrect dose of his/her Metoprolol that resulted in the resident being transferred to the hospital and subsequently admitted .</p> <p>Cross reference F 658</p>		