STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075386	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Knoll Center for Health & Rehabilitation	41 Skokorat Street Seymour, CT 06483

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for medication errors, the facility failed to ensure medication was administered in accordance with physician orders, and failed to ensure staff read the manufacturer label prior to administering a medication, resulting in a medication error. The findings include: Resident #1 had a diagnosis of rheumatoid arthritis. Physician order dated 6/4/2025 directed to administer Methotrexate (immunosuppressive drug use to treat rheumatoid arthritis) subcutaneous solution auto-injector 10 milligrams (mg)/0.4 milliliters (ml). Inject 25 mg subcutaneously every Tuesday. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating he/she was alert and oriented. The Resident Care Plan (RCP) dated 6/10/2025 identified Resident #1 had arthritis. Interventions directed to administer medications as ordered. Facility incident report dated 6/18/2025 identified Resident #1 received the wrong medication dose. APRN #1's note dated 6/18/2025 at 9:45 AM identified Resident #1 was seen for follow up after he/she was inadvertently given 50 mg of Methotrexate on 6/10 and on 6/17/2025 (prescribed dose was Methotrexate 25 mg). The note indicated that APRN #1 was notified by the pharmacy manager that the pharmacy had sent the incorrect dose with an incorrect label which led to the administration of the 50 mg dose. Resident #1's rheumatologist (prescribing physician) was notified and directed to hold the next scheduled dose of Methotrexate (scheduled on 6/24/2025). Further, the rheumatologist directed blood work: a complete blood count, basic metabolic panel, and Methotrexate levels. Blood work was obtained which showed no significant abnormalities and the resident was started on IV hydration, and the plan of care was discussed with Resident #1. APRN #1's note dated 6/19/2025 at 8 AM identified Resident #1 was seen for follow up, and had no adverse effects from the medication error, and no significant abnormalities were noted in the laboratory results. Facility incident summary dated 6/19/2025 identified the facility received a call from the pharmacy and the pharmacy explained the label on the packaging of the Methotrexate was transcribed incorrectly by the pharmacy. The Methotrexate vial sent to the facility on 6/5/2025 stated 50 mg was two (2) ml and the packaging label stated 25 mg was two (2) ml. Resident #1 should have received 25 mg. LPN #1 and LPN #2 stated when they administered the Methotrexate on 6/10 and 6/17/2025, they administered the full vial. LPN #1 and LPN #2 indicated they read the packaging label and dispensed the medication due to the packaging label saying 25 mg was two (2) ml. Resident #1 was stable and aware of the medication error. The APRN note dated 6/20/2025 at 8:30 AM identified the IV fluids were discontinued, and Resident #1 had not experienced any adverse side effects or significant abnormalities in the laboratory results after the medication error. Interview with APRN #1 on 7/21/2025 at 11:01 AM identified she was notified by the pharmacy on 6/18/2025 that the Methotrexate was mislabeled by the pharmacy (with the wrong dose instructions) and that Resident #1 received the wrong dose on 6/10 and 6/17/2025. APRN #1 identified Resident #1 had no adverse effect from the medication error; blood work was normal, IV fluids were administered as a precaution, and Resident #1 was monitored for nausea, vomiting or diarrhea. Interview with the Pharmacy Manager on 7/21/2025 at 11:22 AM identified she was notified of the error on 6/17/2025 when the facility reordered the Methotrexate too early. The pharmacy identified the label direction placed on the vials by the pharmacy directed 25 mg was two (2) ml of solution, but the manufacturer label said 25 mg was per one (1) ml. The Pharmacy Manager stated she did not know why the pharmacy label was incorrect, and indicated the pharmacy contacted the facility about the error. Interview with LPN #1 on 7/21/2025 at 11:47 AM identified she administered the Methotrexate on 6/17/2025. LPN #1 stated the pharmacy label was wrapped around the vial and she gave the dose per the electronic health record but did not remember the dose she gave. LPN #1 further stated she does not check the manufacturer labels on a vial, and she only checks the label that the pharmacy attaches to a vial. Interview with LPN #2 on 7/21/2025 at 11:56 AM identified administered the Methotrexate on 6/10/2025, but did not remember what dose he administered. LPN #2 stated he checked the physician order prior to administering the medication and discarded the vial afterwards. LPN #2 indicated the dose he administered was from a new, unopened vial and he administered the entire vial. Interview with the Director of Nursing (DNS) on 7/21/2025 at 12:51 PM identified LPN #2 administered the wrong dose of Methotrexate on 6/10 and LPN #1 administered the wrong dose of Methotrexate on 6/17/2025. The DNS indicated both nurses administered Methotrexate 50 mg, instead of the ordered dose of 25 mg. The DNS stated the pharmacy label indicated a 25 mg dose was two (2) ml of the

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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 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. (continued on next page)

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The Resident Care Plan (RCP) dated 6/10/2025 identified Resident #1 had arthritis. Interventions directed to administer medications as ordered. Facility incident report dated 6/18/2025 identified Resident #1 received the wrong medication dose. APRN #1's note dated 6/18/2025 at 9:45 AM identified Resident #1 was seen for follow up after he/she was inadvertently given 50 mg of Methotrexate on 6/10 and on 6/17/2025 (prescribed dose was Methotrexate 25 mg). The note indicated that APRN #1 was notified by the pharmacy manager that the pharmacy had sent the incorrect dose with an incorrect label which led to the administration of the 50 mg dose. Resident #1's rheumatologist (prescribing physician) was notified and directed to hold the next scheduled dose of Methotrexate (scheduled on 6/24/2025). Further, the rheumatologist directed blood work: a complete blood count, basic metabolic panel, and Methotrexate levels. Blood work was obtained which showed no significant abnormalities and the resident was started on IV hydration, and the plan of care was discussed with Resident #1. APRN #1's note dated 6/19/2025 at 8 AM identified Resident #1 was seen for follow up, and had no adverse effects from the medication error, and no significant abnormalities were noted in the laboratory results. Facility incident summary dated 6/19/2025 identified the facility received a call from the pharmacy and the pharmacy explained the label on the packaging of the Methotrexate was transcribed incorrectly by the pharmacy. The Methotrexate vial sent to the facility on 6/5/2025 stated 50 mg was two (2) ml and the packaging label stated 25 mg was two (2) ml. Resident #1 should have received 25 mg. LPN #1 and LPN #2 stated when they administered the Methotrexate on 6/10 and 6/17/2025, they administered the full vial. LPN #1 and LPN #2 indicated they read the packaging label and dispensed the medication due to the packaging label saying 25 mg was two (2) ml. Resident #1 was stable and aware of the medication error. Interview with APRN #1 on 7/21/2025 at 11:01 AM identified she was notified by the pharmacy on 6/18/2025 that the Methotrexate was mislabeled by the pharmacy (with the wrong dose instructions) and that Resident #1 received the wrong dose of Methotrexate on 6/10 and 6/17/2025 (received 50 mg instead of the 25 mg ordered). APRN #1 identified Resident #1 had no adverse effect from the medication error; blood work was normal, IV fluids were administered as a precaution, and Resident #1 was monitored for nausea, vomiting or diarrhea. Interview with the Pharmacy Manager on 7/21/2025 at 11:22 AM identified she was notified of the error on 6/17/2025 when the facility reordered the Methotrexate too early. The pharmacy identified the label directions placed on the vials by the pharmacy were incorrect. The labels directed 25 mg was two (2) ml of solution, but the manufacturer label said 25 mg was per one (1) ml. The Pharmacy Manager stated she did not know why the pharmacy label was incorrect, and indicated the pharmacy contacted the facility about the error. Interview with LPN #1 on 7/21/2025 at 11:47 AM identified she administered the Methotrexate dose per the electronic health record on 6/17/2025, but did not remember the dose she administered. LPN #1 further stated she does not check the manufacturer labels on a vial, and she only checks the label that the pharmacy attaches to a vial. Interview with LPN #2 on 7/21/2025 at 11:56 AM identified administered the Methotrexate on 6/10/2025 and indicated the dose he administered was from a new, unopened vial and he administered the entire vial. Interview with the Director of Nursing (DNS) on 7/21/2025 at 12:51 PM identified LPN #2 administered the wrong dose of Methotrexate on 6/10 and LPN #1 administered the wrong dose of Methotrexate on 6/17/2025. The DNS indicated both nurses administered Methotrexate 50 mg, instead of the ordered dose of 25 mg. The DNS stated reason for the error was that the pharmacy label was wrong. The pharmacy label indicated a 25 mg dose was two (2) ml of the solution, and the manufacturer's label on the vial indicated 50 mg was two (2) ml of solution. The DNS stated neither LPN #1 or LPN #2 checked the manufacturer's label against the pharmacy label and did not identify the discrepancy in labeling and Resident #1 received the wrong dose. Interview failed to identify why staff did not read both labels on the Methotrexate vials. Subsequent to