STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335767	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OUR LADY OF MERCY LIFE CENTER	**2 MERCYCARE LANE GUILDERLAND, NY 12084**

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (Case #NY 373), the facility did not ensure medications were administered per prescriber's order for 1 (Resident #2) of 3 residents reviewed for medication administration. Specifically, the facility did not ensure Resident #2 received prescribed medication for high blood pressure within the parameters ordered. This is evidenced by: The Policy and Procedure (P&P) titled Medication Administration - General last reviewed on 7/1/2019, documented each resident would receive all medications as ordered by the physician. Staff were to note times medications were due, doses to be held, and any other pertinent information. Resident #2: Resident #2 was admitted to the facility with diabetes type 2 with skin complications, heart failure, and hypertension. The Minimum Data Set (MDS - an assessment tool) dated 11/2/2018, documented the resident was cognitively intact. The Comprehensive Care Plan (CCP) for Alteration in Cardiac Function as manifested by [MEDICAL CONDITION] and high blood pressure initiated on 2/15/2018, documented the resident was to be given medications as ordered. The Medication Review Report dated 11/19/2018, documented an order dated 9/26/2018 for [MEDICATION NAME] (antihypertensive medication) 30 mg tablet extended release (ER) 24 hour, to be given two times a day for hypertension. The medication was to be held when the systolic blood pressure (SBP) was less than 140. The Medication Administration Record [REDACTED] 11/1/2018 at 9:00 PM, BP was 137/68; medication was given. 11/3/2018 at 9:00 PM, BP was 128/67; medication was given. 11/8/2018 at 9:00 PM, BP was 134/72; medication was given. 11/9/2018 at 9:00 AM, BP was 134/72; medication was given. 11/9/2018 at 9:00 AM, BP was 138/70; medication was given. 11/12/2018 at 9:00 PM, BP was 130/74; medication was given. 11/14/2018 at 9:00 PM, BP was 132/66; medication was given. 11/15/2018 at 9:00 PM, BP was 126/67; medication was given. 11/17/2018 at 9:00 PM, BP was 137/68; medication was given. 11/18/2018 at 9:00 PM, BP was 134/72; medication was given. 11/19/2018 at 9:00 PM, BP was 128/70; medication was given. 11/26/2018 at 9:00 PM, BP was 116/72; medication was given. 11/28/2018 at 9:00 AM, BP was 120/64; medication was given. 11/28/2018 at 9:00 PM, BP was 128/68; medication was given. 11/29/2018 at 9:00 PM, BP was 138/74; medication was given. The MAR indicated [REDACTED] 12/1/2018 at 9:00 PM, BP was 122/70; medication was given. 12/2/2018 at 9:00 AM, BP was 132/61; medication was given. 12/2/2018 at 9:00 PM, BP was 126/68; medication was given. 12/8/2018 at 9:00 PM, BP was 114/76; medication was given. 12/9/2018 at 9:00 PM, BP was 128/75; medication was given. 12/10/2018 at 9:00 PM, BP was 118/68; medication was given. During an interview on 2/10/2020 at 1:52 PM, the Assistant Director of Nursing (ADON) stated, the LPN (licensed practical nurse) should have held the medication per order when Resident #2's SBP was less than 140. During an interview on 2/10/2020 at 2:18 PM, Director of Nursing (DON) stated, if she had been made aware of the medication errors there would have been medication error reports documented. She stated the nurses should not have given the medication when Resident #2's SBP was below the parameter of 140. During an interview on 3/2/2020 at 10:32 AM, physician (MD) #1 stated, a parameter was put on the order for the [MEDICATION NAME] because the physician would not want to give a medication that would lower Resident #2's pressure any lower than he/she would want it to be. She stated Resident #2 should no have received the medication when the SBP was lower than the parameter on the order. 10 NYCRR 415.12(m)(2)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.