STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315017	A. BUILDING _____ B. WING _____	06/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BERGEN NEW BRIDGE MEDICAL CENTER	230 E RIDGEWOOD AVE PARAMUS, NJ 07652

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** C#: NJ 0 Based on interviews, review of medical records and review of other pertinent facility documentation, it was determined that the facility failed to maintain the accepted professional standards for medication administration by administering the wrong medication to the wrong resident (Resident #2). In addition, failed to follow their policies and procedure titled General Guidelines for the Administration of Medication and Medication Incidents when on 4/12/2020, during the 9 p.m. medication pass, the Licensed Practical Nurse(LPN) poured Resident #3's medication in a cup and gave it to the Assistant Director of Nursing (ADN) to administer it to Resident #3. Instead the ADN administered Resident 3#'s medication which were poured by the LPN to Resident #2. At approximately 11:15 p.m., Resident #2 was found unconscious by the oncoming nurse on the 11 p.m. - 7 a.m. shift. This deficient practice was identified for 1 of 3 sampled residents reviewed for receiving the wrong medication, as evidenced by the following: A review of Electronic Medical Record (EMR) for Resident #2 revealed the following: The Admission sheet revealed Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Physician's Renewal Order (PRO) in the EMR indicated the following medications were prescribed for Resident #2, by the physician were [MEDICATION NAME] ([MEDICATION NAME]) Tab (tablet) 500 milligram (MG) orally. Give 2 tablets (1000 MG) at bedtime at 9:00 p.m for MOOD, dated 5/17/2017. [MEDICATION NAME] ([MEDICATION NAME]) Tab 10 MG tab. Give 1 Tablet orally at 9:00 p.m., for [MEDICAL CONDITION]. (May cause drowsiness), dated 5/26/2017. [MEDICATION NAME] ([MEDICATION NAME]) Tab 3 MG tab. Give 2 tablets (6 MG) orally daily at bedtime for [MEDICAL CONDITION], dated 4/23/2018. Review of the Interdisciplinary Progress Notes (IPN) dated 4/13/2020 at 1:27 a.m., written by the Registered Nurse (RN #1) who found Resident #2 unconscious while making her rounds revealed the Resident was found unresponsive at 11:15 p.m. The IPN also showed that Resident #2 was assessed and oxygen (O2) was initiated via (by) a nonrebreather mask. The Rapid Response Team (RRT) was called and arrived at 11:35 p.m. The IPN also revealed that an intravenous line was placed into Resident #2's left hand for intravenous fluids (IVF), which was started on the unit. Resident #2 was then transferred to the ER (emergency room) at 12:00 a.m. for an evaluation. The surveyor requested the investigation, which was provided by the Director of Nursing (DON) on 6/12/2020, review of the incident report titled Incidents: Modify Incident report with an incident date of 4/12/2020, completed by the ADN, revealed that Resident #2 had a Loss of Consciousness, and that the ADN give the wrong meds, [MEDICATION NAME] 30 MG tab and [MEDICATION NAME] 2 MG tab to (Resident #2) . Review of a facility document titled Individual Statement Form (ISF) dated 4/15/2020, written by the LPN revealed that on 4/12/2020 on the 3:00 P.M. to 11:00 p.m. shift, the LPN poured Resident #3's medication in a paper cup, and wrote the Resident's name and room number on a second cup for the ADN to administer the medications to Resident #3.The statement further explained that at 10:00 p.m., Resident #3 asked the LPN for his/her medications. The LPN then called the ADN and asked her who she gave Resident #2's medication to, and the ADN told the LPN that she gave Resident #3's medication to Resident #2, and it was a mistake. Review of a second ISF dated 4/25/2020, written by the ADN revealed that on 4/12/2020 at 9:30 p.m., I was helping (the LPN) to administer medications. I administered the [MEDICATION NAME] 30 MG and [MEDICATION NAME] 2 MG to (Resident #2, when it should have been for (Resident #3). A review of the EMR for Resident #3's revealed the following: The Admission Sheet revealed the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS dated [DATE], revealed that Resident #3 had a BIMS score of 15/15, which indicated the Resident was cognitively intact. The PRO in the EMR indicated the following medications were prescribed, by the physician for Resident #3: [MEDICATION NAME] ([MEDICATION NAME]) tablet 2 MG. 1 tab orally daily at 9:00 p.m. for Anxiety, dated 3/27/2018. [MEDICATION NAME] tab 10MG, 3 tablets (30MG) orally at 6:00 A.M., 2:00 p.m., and 10:00 p.m. for pain management, dated 6/12/2018. During a telephone interview on 6/11/2020 at 10:53 a.m., RN #1 stated she found Resident #2 unresponsive lying in bed, during her rounds. RN #1 also indicated she told LPN #1 that Resident #2 was unresponsive. LPN #1 explained to RN #1 that Resident #2 was given Resident #3's medication, and she told the LPN to call the RRT. RN #1 also indicated that she took the crash cart to Resident #2's room and placed the O2 nonrebreather on the Resident, however; the Resident was not responding. RN #1 further explained at this time the RRT arrived in Resident 2's room and took over caring for the resident. During an interview on 6/11/2020 at 11:15 a.m., LPN #1 stated that around 9:00 p.m., the ADN was assisting her with administering the medication, she wrote Resident #3's name and room number on the cup and gave the cup to the ADN to administer the medication to the resident and then signed off on the Medication Administration Record. LPN #1 indicated that Resident #3 came to her around 9:30 p.m. and asked for her medication. The LPN explained she then called the ADN and asked her who she gave Resident #3 medication to, and the ADN indicated she gave the medication to Resident #2. In addition, LPN #1 stated when giving medication the policy is to check the (resident's) hand band which has the Resident's name. During a telephone interview on 6/11/2020 at 1:17 p.m., the RRT Physician stated that she was told that Resident #2 was given [MEDICATION NAME] and [MEDICATION NAME]. The RRT Physician also indicated, when she arrived at the scene the Resident #2 was lethargic, and the Resident's blood pressure and O2 were fluctuating. The RRT Physician also indicated Resident #2 was placed on a 100 % non-rebreather O2 and [MEDICATION NAME] was administered. In addition, the Physician stated that Resident #2 responded to the [MEDICATION NAME] and was stable. During an interview on 6/11/2020 at 11:52 a.m., with the with the DON, in the presence of the ADN, the DON indicated the ADN should have checked Resident #2's hand band prior to administering the medication. During an interview on 6/12/20 at 9:39 a.m., the ADN stated she was helping the LPN to administer the 9 p.m., medication. The LPN prepared Resident #3's medication and indicated the medication was for Resident #3 and gave her the medication to administer to Resident #3. However, the ADN indicated she did not look to see if it was a male or female resident and she administered Resident #3's medication to the wrong resident, Resident #2. The ADN also indicated that prior to administering the medication to Resident #2, she failed to check the Physician's order, Medication Administration Record, [REDACTED]. In addition, the ADN stated she failed to check Resident#2's name wrist band and she was not supposed to administer medications she did not prepare. Review of the facility policy titled, General Guidelines for the Administration, dated 1/2019, under Procedure #3, included the following: . The nurse observes the five rights in administering each medication: a). The right resident b). The right time c). The right medication d). The right dose Under #5. Nurse identifies resident by name and by the facility identification system in place (ID bracelet, photo, etc.). Review of a second facility's policy titled Medication Incidents, dated 1/19, included under Definitions: Medication Incident: Any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health professional Under Severity of Event included Incident Harm, Category L4. An incident occurred that resulted in the need for treatment or intervention and caused temporary patient harm. N.J.A.C:8:39-29.2(d)

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