STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225264	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRANDON WOODS OF NEW BEDFORD	**397 COUNTY STREET NEW BEDFORD, MA 02740**

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 records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure he/she was free from a significant medication error, when Resident #1 was administered medications that were not ordered for him/her by his/her physician including a medication which he/she was allergic to. Resident #1 required transfer to the Hospital Emergency Department (ED) for evaluation. Findings include: The Facility Policy, titled Administering Medications, revised December 2012, indicated that the individual administering medications must verify the resident's identity before giving the resident his/her medications. The Policy indicated that the individual administering medications must check the label three times to verify the (5 Rights of Medication Administration) right resident, right medication, right dosage, right time and right route of administration before giving the medication and must check each resident's allergies [REDACTED]. A Medication Error Incident Report, dated 6/05/20, indicated Resident #1 received another resident's medications in error at 8:45 A.M. The Report indicated that the Nurse failed to identify Resident #1 during medication administration, did not follow 5 Rights of Medication Administration and did not follow facility policy and procedure. The Facility's Internal Investigation Report, dated 6/5/20, indicated that Resident #1 was administered the following medications, in error: - [MEDICATION NAME] 6.25 mg (used to treat high blood pressure); - [MEDICATION NAME] 100 mg (used to prevent and control [MEDICAL CONDITION]); - Vitamin D3 2000 Units (vitamin helps body absorb calcium and phosphorus); - [MEDICATION NAME] 250 mg (used to treat [MEDICAL CONDITION]); - [MEDICATION NAME] 5 mg (used to treat enlarged prostate in men); - Myrbetriq 50 mg (used to treat an overactive bladder); - [MEDICATION NAME] 20 mg (used to treat [MEDICAL CONDITION] reflux). The Report indicated that the Nurse did not identify Resident #1 prior to administering medications, did not follow the 5 rights of medication administration and failed to follow facility policy. Review of Resident #1's physician's orders [REDACTED].#1 was not prescribed the medications [MEDICATION NAME], Vitamin D3, [MEDICATION NAME], Myrbetriq and [MEDICATION NAME]. The Orders indicated Resident #1 had an allergy to [MEDICATION NAME]. During an interview on 8/19/20 at 2:20 P.M., the Nurse said she went into Resident #1's room to administer his/her medications, that she had never taken care of Resident #1 and said she failed to identify Resident #1 prior to administering his/her medications on 6/5/20. The Nurse said when she went to administer Resident #2 his/her medications, she realized she had already signed off his/her medications in the Medication Administration Record [REDACTED]. During an interview on 8/19/20 at 11:48 A.M., the Director of Nurses (DON) said that it is his expectation and Facility policy that nurses positively identify the resident prior to the administration of any medication and said the Nurse did not identify Resident #1, did not follow the Facility's policy and admitted to making the medication error.

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.