

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Beechwood Homes		STREET ADDRESS, CITY, STATE, ZIP CODE 2235 Millersport Highway Getzville, NY 14068	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a Complaint investigation (#NY00383549) the facility did not ensure that residents are free of significant medication errors for one (1) (Resident #1) of three (3) residents reviewed. Specifically, on 06/11/2025 Licensed Practical Nurse #1 erroneously administered Resident #2's morning medications to Resident #1 which resulted in a significant medication error. The finding is: The policy and procedure titled Medication Administration effective 05/11/2023 documented medications shall be administered in accordance with established procedures including right resident, right medication, right dose, right time, right route, right reason, and right documentation. Resident #1 had diagnoses including cerebrovascular disease (group of conditions that affect blood flow to the brain), vascular dementia (dementia caused by brain damage from impaired blood flow), and hypertension. The Minimum Data Set (a resident assessment tool) dated 05/16/2025 documented Resident #1 was cognitively intact and received medications including but not limited to antipsychotic (medication used to treat psychosis), antidepressant, and antiplatelet (medication used to prevent blood clots). Resident #2 had diagnoses including congestive heart failure, hypertension (high blood pressure), and edema (swelling). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and received medications including but not limited to anticonvulsant (medication used to treat seizures), diuretic (used to treat edema), and opioid (narcotic pain reliever). Resident #2 Physician orders included gabapentin 400 milligrams twice a day by mouth for neuropathy, nerve pain, (date initiated 12/10/2024). Oxycontin ER (extended release) 15 milligrams every twelve hours by mouth for pain (date initiated 06/01/2025), bumetanide 1 milligram once a day by mouth for fluid retention (date initiated 12/05/2024), Entresto 24-26 milligrams twice a day by mouth for congestive heart failure (date initiated 12/05/2024), and Flomax 0.4 milligrams twice a day by mouth for benign prostatic hyperplasia, enlarged prostate, (date initiated 12/05/2024). The facility Medication Error Report dated 06/11/2025 documented a medication error was made by Licensed Practical Nurse #1 involving Resident #1. Licensed Practical Nurse #1 administered medications including but not limited to gabapentin (used to treat seizures, nerve pain, and restless leg syndrome), oxycontin ER (extended release/narcotic pain reliever), bumetanide (used to treat edema), Entresto (used to treat chronic heart failure), and Flomax (used to relax muscles in the bladder) to the wrong resident. The Medical Director was notified and gave new orders to monitor vital signs every two hours for eight hours then every shift for twenty-four hours and monitor for adverse effects. Resident #1 exhibited low blood pressure and lethargy after the medication administration. The Medical Director was updated 6/11/2025, and new orders were received to hold scheduled 12:00 PM and 2:00 PM medications, insert peripheral intravenous device (thin flexible tube used to administer fluids directly in to a vein) and start 0.9% normal saline at 100 ml (milliliters) per hour for a total of one liter (1000 milliliters), and apply thigh high thrombo-embolus deterrent stockings (specially designed stockings to help reduce the risk of developing a blood clot in lower extremity). During an interview on 07/03/2025 at 9:27 AM, Licensed Practical Nurse #1 stated they started a medication pass and poured medications for another resident (#2). They stated they became distracted during the medication pass by another resident and then a resident's family member. Licensed Practical Nurse #1 stated they mistakenly administered another resident's (#2) medications to Resident #1 and reported the error immediately upon identification of the error. During an interview on 07/03/2025 at 10:07 AM, the Director of Nursing stated Resident #1 received Resident #2's medications, including cardiac medications; and would consider the error a significant medication error. Additionally, the Director of Nursing stated the Medical Director was notified and when the resident started to exhibit low blood pressure and lethargy, intravenous fluids were administered to prevent dehydration. During an interview on 07/02/2025 at 10:57 AM, the Medical Director stated they expected the seven rights of medication administration to be followed by all nurses and medications be administered to the correct resident. Additionally, the Medical Director stated the medications Resident #1 received in error were important medications but had a mild and short-term impact on the resident, and the intravenous fluids were given as a precaution to avoid dehydration and hospitalization. 10 NYCRR 415.12(m)(2)</p>		