STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395019	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Meadow Springs	845 Germantown Pike Plymouth Meeting, PA 19462

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record reviews, interviews with staff and and policy and procedure review, it was determined that the facility failed to ensure that physician's orders were follow for one of ten residents reviewed. (Resident R1) Findings include: A review of the facility policy titled administering medications August 18, 2022 revealed that medications and treatments were to be administrated in a safe and timely manner as prescribed by the physician. The policy also indicated that medications and treatments must be administered in accordance with the physician's orders, including any required time frame or parameters as specified by the physician. This policy said that if the drug was withheld the individual administering the medication was responsible to use the correct documentation on the MAR (Medication Administration Record) space provided for that drug. The policy indicated that the person administering the medication was responsible for recording the date and time of administration. A review of the policy titled physicians' medication orders dated August 18, 2024 revealed that a medication or treatment was to be administered upon a physician's order by a person licensed to prescribed medications and treatments in the State. The policy also said that verbal orders for treatments and drugs were to be received by licensed nurses. Review of Resident R1 was readmitted to the nursing facility on August 16, 2024 with a diagnosis of replaced dislodged DOB [NAME] tube (used for enteral feedings and medications for residents with swallowing problems), aspiration pneumonitis, and respiratory failure. Review of physician's orders for August, 2024 revealed a physician's order for Metoprolol tartrate (drug therapy for angina) 25 milligrams (mg) to be given every 12 hours and hold for systolic blood pressure less than 100 or heart rate less than 60. Continued review of physician's orders revealed an order for Midodrine (drug therapy for high blood pressure) 10 mg three times a day and hold for systolic blood pressure greater than 130. Review of Resident R1's August 2024 Medication Administration Record (MAR) revealed than on August 17, 2024, at 5:00 a.m., the resident's blood pressure was 132/74 and the nurse responsible failed to hold Midodrine 10 mg and administered medication to Resident R1. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of August 2024 MAR revealed that on August 18, 2024 the nursing staff member documented holding Midodrine 10 mg at 9:00 a.m., however the resident's blood pressure was 109/49. The nurse responsible for administering medications documented that the medication was held; which was not in accordance with the physician's orders. 28 Pa. Code 211.12(d)(1) Nursing services

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record review, interviews with staff and and policy and procedure review, it was determined that the facility failed to ensure that a doppler study was completed as ordered by the physician for one of ten residents reviewed. (Resident R1) Findings include: Clinical record review revealed that Resident R1 was readmitted to the nursing facility on August 16, 2024 with a diagnosis of replaced dislodged DOB [NAME] tube (used for enteral feedings and medications for residents with swallowing problems), aspiration pneumonitis, and respiratory failure. Clinical record review revealed that the nurse practitioner's progress note dated August 22, 2024 indicated that Resident R1 was ordered a doppler (a test to estimate the blood flow through your blood vessels) study of the left arm due to swelling and pain. There was no doppler study of the left arm completed and available for review. Clinical record review revealed that the nurse practitioner ordered a STAT (emergency) doppler study for acute pain and swelling of the left arm for Resident R1 at 12:30 p.m., on August 23, 2024. Interview with the director of nursing Employee E7, at 1:00 p.m., on November 14, 2024 revealed that STAT means emergency and that the facility would complete the study within four hours of the time the physician or nurse practitioner ordered the testing. There was no documentation to indicate that a STAT doppler study of the left arm was available for review on August 23 or 24, 2024. Clinical record documentation indicated that resident R1 was admitted to the hospital for hypotension and gastrointestinal bleeding at 7:30 a.m., on August 24, 2024. 28 Pa. Code 211.12(d)(1) Nursing services

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record reviews, review of physican orders and interviews with staff, it was determined that the facility failed to ensure complete documetation related to blood pressure for one of ten residents. (Resident R1) Findings include: A review of the facility policy titled administering medications August 18, 2022 revealed that medications and treatments were to be administrated in a safe and timely manner as prescribed by the physician. The policy also indicated that medications and treatments must be administered in accordance with the physician's orders, including any required time frame or parameters as specified by the physician. This policy said that if the drug was withheld the individual administering the medication was responsible to use the correct documentation on the MAR (Medication Administration Record) space provided for that drug. The policy indicated that the person administering the medication was responsible for recording the date and time of administration. Clinical record review revealed that Resident R1 was readmitted to the nursing facility on August 16, 2024 with a diagnosis of replaced dislodged DOB [NAME] tube (used for enteral feedings and medications for residents with swallowing problems), aspiration pneumonitis, and respiratory failure. Clinical record review for the month of August, 2024 revealed a physician's order and care plan for Metoprolol tartrate (drug therapy for angina) 25 milligrams (mg) to be given every 12 hours and hold for systolic blood pressure less than 100 or heart rate less than 60. Clinical record review for Resident R1 indicated a physician's order for Midodrine (drug therapy for high blood pressure) 10 mg three times a day and hold for systolic blood pressure greater than 130. Review of Resident R1's August 2024 Medication Administration Record revealed that on August 17, 2024, at 9:00 p.m., the nurse failed to record the blood pressure and the administration of the medication according to physician' s orders. On August 19, 2024 at 1:00 p.m., Resident R1's blood pressure was 138/65. The nurse responsible for administration of the medication failed to document that the medication was held in accordance with physician's orders and standards of practice for medication administration. 28 Pa. Code 211.10 (c) Resident care plicies 28 Pa. Code 211.12(d)(1) Nursing services