

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Garden Spring Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1113 North Easton Road Willow Grove, PA 19090	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>43883</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for one of five sampled residents. (Resident 1)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included gastroesophageal reflux disease (acid reflux), pain, and neuropathy (nerve damage). Physician's orders dated July 26, 2024, directed staff to administer Acetaminophen (a medication for pain) and gabapentin (a medication for nerve pain) at 6:00 a.m. daily. A physician's order dated July 27, 2024, directed staff to administer omeprazole (a medication to treat acid reflux) at 6:00 a.m. daily. There was no evidence that the medications were offered or administered on August 7, 2024, per the physician's orders.</p> <p>In an interview on August 8, 2024, at 2:07 p.m., the Director of Nursing confirmed there was no evidence that the medications were administered per the physician's orders.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>43883</p> <p>Based on facility policy review, observation, and staff interview, it was determined that the facility failed to maintain a medication error rate of less than five percent (%) on one of five nursing units. (Section 2)</p> <p>Findings include:</p> <p>A review of the facility policy entitled, Administering Medications, last reviewed September 2023, revealed that Medications were to be administered in accordance with the prescriber's orders, which included any required timeframe. Medications were to be administered within one hour of their prescribed time.</p> <p>Clinical record review revealed that Resident 2 had diagnoses that included major depressive disorder and multiple sclerosis. A review of physician's orders dated June 29, 2018, June 9, 2021, March 28, 2023, and August 5, 2024, revealed that staff were to administer the following medications at 8:00 a.m. daily: vitamin D3 1000 international units (IU), Zeposia 0.92 milligrams (mg), escitalopram 20 mg, and Bactrim 160 mg. Observation of the medication pass on August 8, 2024, revealed that licensed practical nurse (LPN) 1 did not administer the medications until 9:30 a.m.</p> <p>Clinical record review revealed that Resident 3 had diagnoses that included depression, allergies, hypertension (high blood pressure), and pain. A review of physician's orders dated April 12, 2024, April 24, 2024, May 16, 2024, July 11, 2024, July 16, 2024, and July 30, 2024, revealed that staff were to administer the following medications at 8:00 a.m. daily: cholecalciferol (vitamin D) 50 micrograms (mcg), bupropion (a medication for depression) 300 mg, lidocaine patch 4 % to the right knee, fluticasone propionate (a medication for allergies) 50 mcg, sertraline (a medication for depression) 75 mg, and lisinopril (a medication for high blood pressure) 5 mg. Observation of the medication pass on August 8, 2024, revealed that LPN 1 did not administer the medications until 9:40 a.m.</p> <p>Observation during the medication pass on August 8, 2024, from 9:30 a.m. to 9:40 a.m., revealed 28 opportunities with 10 errors which resulted in a medication error rate of 35.7%.</p> <p>In an interview on August 8, 2024, at 2:10 p.m., the Director of Nursing confirmed that the medications should have been administered by 9:00 a.m.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		