STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395258	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Lake Healthcare Center	905 Tower Road Bristol, PA 19007

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** 46106 Based on the review of clinical record, interview with resident and staff, it was determined that the facility failed to ensure that each resident receive the medications that were ordered for by their physician and do not be administer medications ordered for another resident for 1 of 4 residents reviewed. (Resident R 1) Findings Include: Review of facility policy Administering Medication states that observe the five right in giving each medication, the right resident, the right time, the right medication, the right dose and the right route. Review Physician Orders policy states medication administration record/ treatment administration record the legal medical record for recording medication and treatment. Review of Resident's R1 clinical record, revealed the diagnosis of dementia (progressive degenerative disease of the brain) without behaviors and high blood pressure. Reviewed the investigation reported revealed that on October 5, 2024, at 0900 (9:00 a.m.), resident a [AGE] year-old male with Diagnosis of dementia and HTN (hypertension- high blood pressure) and a BIM (Brief Interview of Mental Status)'s score of 7, was administered medications in error. Resident R1 received Ferrous Sulfate 325mg (milligrams), Gabapentin 800 mg, Lipro insulin 2 units and Keppra 750 mg, that were entered into his chart in error. Doctor and RR (responsible party) made aware. Resident R1 placed on enhanced monitoring. Blood sugar 99. Resident's family requested that resident be sent to the ER (emergency room) for evaluation routine change in mental status. Resident R1 sent 911 (Emergency Medical Services) to ER for evaluation and admitted . Facility administration director nursing made aware. Reviewed witness statements from the Registered Nurse, Employee E4 revealed on October 4, 2024, at 6:45 pm, [Resident R2] was transferred to Sliver Lake health care center. I transcribed some of [Resident R2] medication from 3-b under [Resident R1] in room [ROOM NUMBER]-A not re realizing they were different residents with the same last names. On October 5, 2024, at 2:30am, I was informed by supervisor that some of the [Resident R2] meds were transcribe under [Resident R1]. I immediately rushed in the room to assess the resident. Vital includes, 114/70, 58, 97.6, 20, 98 quickly informed manger and [Resident R1] daughter at bed side made aware. 911 called never alone called, [Resident R1] send to . ER Via Ambulance for evaluation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395258	A. Building B. Wing	10/09/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed witness statements from the licensed practical nurse, Employee E5 revealed on October 5, 2024, I dispensed all AM medications ordered in the facility for [Resident R1]. After I passed medication around 11 am, I noticed his sugar was low, gave him a pudding and his sugar was elevated. The daughter came in to visit, she identified her father was not normal. I explained that this maybe a response to his new medication. The family was unaware of the changes in medication. I contacted the supervisor, Employee 6 came up to speak with the family. During medication review the diagnosis didn't match the order under [Resident R1]. At that time supervisor identified that there was a name alert and that the new medications were put into the wrong resident chart. Reviewed witness statements Supervisor Registered Nurse, Employee E6 revealed when I was making rounds Saturday, [Licensed Practical Nurse, Employee E5], told me that [Resident R1] daughter was concerned that new medication was ordered for her father without her involvement. After [Licensed Practical Nurse, Employee E5], told me what the medication were, I remembered that there was an admission with the same last name that came in Friday night, I did a quick review of the chart for [Resident R2] in post-acute and realized that medications that should have been entered and ordered for her were entered on [Resident's R1] MAR (medication Administration Record) accidentally. [Registered Nurse, Employee E4], had entered the orders on Friday evening and she was there Saturday morning. I told registered [Nurse, Employee E4] about the error and informed . Reviewed additional information from the hospital discharge records revealed presented to the ED (Emergency Department) with confusion and lethargy due to accidental administration of another resident's medication Sliver Lake Nursing Home, which included insulin aspart 2 units, Gabapentin 800mg and Keppra 750mg. Resident R1 arrived at the ED sleepy but alert and oriented. Resident's daughter also noticed speech was slurred. IV (intravenous) fluids in the ED and admitted for continued monitoring of accidental administration of incorrect medication and to rule out TIA/stroke due to change in speech and altered mental status. Labs including CBC (complete blood count), CMP (complete metabolic panel), lipid profile, urinalysis, and urine drug screen were all within normal limits. EKG showed sinus rhythm. Chest x-ray was normal. Interview with Nursing Home Administrator, Employee E1 on October 9, 2024, at 12:00 p.m. stated that it was accidental administration of another resident's medication due to another resident with the same last name. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services.