

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2024
NAME OF PROVIDER OR SUPPLIER Crosslands		STREET ADDRESS, CITY, STATE, ZIP CODE 1660 East Street Road Kennett Square, PA 19348	

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 - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46166</p> <p>Based on clinical record review, staff interviews, and facility policies it was determined that the facility failed to notify the physician in a timely manner of multiple medication errors experienced for 15 of 15 residents reviewed. (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14 and Resident R15).</p> <p>Findings include:</p> <p>Review of information dated January 8, 2024 submitted by the facility to Department of Health revealed the facility has been facing substantial frequency of medication errors (failure to administer a medication as prescribed by their provider). These errors stem from inaccuracies originating within their contracted pharmacy.</p> <p>Interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on January 22, 2024, at 9:10 a.m. revealed Crosslands Nursing Facility conducted numerous internal audits and investigations regarding the medication errors.</p> <p>Review of the facility's investigations and audits revealed, from September 1, 2023, through October 22, 2023, 15 residents experienced 70 medication errors.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 22, 2024, at 11:25 a.m., it was disclosed the attending physicians were not informed of the medication errors occurring until December 14, 2023 (Physician 1 and 3), and December 15, 2023 (Physician 2).</p> <p>The Director of Nursing presented notification forms signed by the attending physicians dated December 14 and December 15, 2023.</p> <p>Interview on January 22, 2024 with the Director of Nursing and the Nursing Home Administrator confirmed that timely physician notification was not provided to the attending physicians of the 15 residents affected by the medication errors.</p> <p>29 Pa. Code 211.12(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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>46166</p> <p>Based on clinical record review, staff interviews, and facility policies it was determined that the facility failed to identify pharmacy delivery errors that in turn caused multiple medication errors experienced by 15 of 15 residents reviewed. (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14 and Resident R15). This deficient practice has been determined to be past non compliance.</p> <p>Findings include:</p> <p>Review of information dated January 8, 2024 submitted by the facility to Department of Health revealed the facility has been facing substantial frequency of medication errors (failure to administer a medication as prescribed by their provider). These errors stem from inaccuracies originating within their contracted pharmacy.</p> <p>Interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on January 22, 2024, at 9:10 a.m. revealed Crosslands Nursing Facility conducted numerous internal audits and investigations regarding the medication errors.</p> <p>Review of the facility's investigations and audits revealed, from September 1, 2023, through October 22, 2023, 15 residents experienced 70 medication errors. The errors are as follows:</p> <p>On September 20, 2023, the facility was unable to administer Gabapentin (medication used for pain treatment) to R1 because the pharmacy delivered the medication late.</p> <p>On September 29, 2023, September 30 ,2023, and on October 2, 2023, the facility was unable to administer Remeron (used as an appetite stimulate) to R2 because the pharmacy delivered the medication late.</p> <p>On September 22, 2023, October 9, 2023, and October 11, 2023, the facility was unable to administer Combigan (eye drops used to treat Glaucoma) to R3 because the pharmacy delivered the medication late.</p> <p>On September 13, 2023, and September 20, 2023, the facility was unable to administer Latanoprost gtts (eye drops used to treat Glaucoma) to R3 because the pharmacy delivered the medication late.</p> <p>On October 4, 2023, twice on October 5, 2023, October 6, 2023, October 8, 2023, October 9, 2023, and October 18, 2023, the facility failed to administer Travatan (eye drops used to treat Glaucoma) to R4 because the pharmacy delivered the medication late.</p> <p>On October 21, 2023, the facility failed to administer Saline Nasal Spray (used to prevent nose bleeds) to R4 because the pharmacy delivered the medication late.</p> <p>On September 21, 2023, and twice on October 11, 2023, the facility failed to administer Cosopt (eye drops used to treat Glaucoma) to R5 because the pharmacy delivered the medication late.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On September 25, 2023, the facility failed to administer Restaseis (eye drops used to treat Glaucoma) to R5 because the pharmacy delivered the medication late.</p> <p>On September 2, 2023, the facility failed to administer Vitamin C to R5 because the pharmacy delivered the medication late.</p> <p>On September 6, 2023, three times on September 8, 2023, twice on September 9, 2023, twice September 12, 2023, the facility failed to administer Oyster Shell (used to treat calcium deficiency) to R6 because the pharmacy delivered the medication late.</p> <p>On September 5, 2023, the facility failed to administer Vitamin D3 (used to treat calcium deficiency) to R6 because the pharmacy delivered the medication late.</p> <p>On September 27, 2023, September 29, 2023, September 30, 2023, and October 1, 2023, the facility failed to administer Vitamin B Complex (used to treat a Vitamin B deficiency) to R6 because the pharmacy delivered the medication late.</p> <p>On September 20, 2023, and September 22, 2023, the facility failed to administer Melatonin (used to treat insomnia) to R6 because the pharmacy delivered the medication late.</p> <p>On September 6, 2023, the facility failed to administer Guafenesin (eye drops used to treat Glaucoma) to R6 because the pharmacy delivered the medication late.</p> <p>On September 6, 2023, the facility failed to administer Ferrous Sulfate (used to treat and prevent iron deficiency) to R6 because the pharmacy delivered the medication late.</p> <p>On September 17, 2023, and September 20, 2023, the facility failed to administer Latanoprost (eye drops used to treat Glaucoma) to R7 because the pharmacy delivered the medication late.</p> <p>On October 8, 2023, and October 9, 2023, the facility failed to administer Bion Tears (used to treat dry eyes) to R7 because the pharmacy delivered the medication late.</p> <p>On September 29, 2023, the facility failed to administer Clonazepam (used to treat restless leg syndrome) to R7 because the pharmacy delivered the medication late.</p> <p>Twice on September 18, 2023, and twice on September 19, 2023, the facility failed to administer Albuterol (used to treat asthma) to R8 because the pharmacy delivered the medication late.</p> <p>Twice on October 4, 2023, the facility failed to administer Rytary (used to treat Parkinsons) to R9 because the pharmacy delivered the medication late.</p> <p>On September 9, 2023, September 10, 2023, October 10, 2023, and October 13, 2023, the facility failed to administer Famotidine (used to treat nausea/vomiting) to R10 because the pharmacy delivered the medication late.</p> <p>On September 29, 2023, the facility failed to administer Remeron (used to treat vascular dementia with anxiety) to R11 because the pharmacy delivered the medication late.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Twice on October 3, 2023, the facility failed to administer Beano (prevents gas buildup in one's stomach) to R12 because the pharmacy delivered the medication late.</p> <p>On October 4, 2023, and October 13, 2023, the facility failed to administer Allegra (used to treat allergies) to R13 because the pharmacy delivered the medication late.</p> <p>On September 23, 2023, the facility failed to administer Centrum (Multivitamins) to R14 because the pharmacy delivered the medication late.</p> <p>On September 20, 2023, the facility failed to administer Senna (used to treat constipation) to R15 because the pharmacy delivered the medication late.</p> <p>Interview conducted with the Director of Nursing and Nursing Home Administrator on January 22, 2023, at 11:15 a.m. confirmed the errors listed above. Further interview with Nursing Home Administrator and Director of Nursing confirmed the facility is searching for a new pharmacy to meet the needs of its residents. The Nursing Home Administrator indicated the facility has met with several pharmacies and proceeding with obtaining contracts with one or more pharmacies.</p> <p>Facility Nursing Home Administrator provided surveyor with education to nursing staff including licensed member regarding policy of Medication Errors with a revision date of December 2023. The nursing staff were also educated on the general policies of medications and treatment.</p> <p>Review of In-Service attendance record and interviews conducted with E1, E2, and E3 confirmed all licensed staff have received the in-service training and understood procedure to identify and correct pharmacy concerns that may lead to medication errors.</p> <p>Surveyor reviewed and confirmed the facility performed pharmacy and medication audits from November 2023, and December 2023.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services</p> <p>28 Pa. Code 211.12(5) Nursing Services</p> <p>28 Pa. Code 201.14(a)(b) Responsibility of licensee</p> <p>28 Pa. Code 201.18. Management.</p>		