STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395400	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susquehanna Health and Wellness Center	745 Old Chickies Hill Road Columbia, PA 17512

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, hospital record, and facility documentation, and staff interviews, it was determined the facility failed to ensure that one of three residents (Resident R1) were free from significant medication errors which resulted in actual harm to Resident R1 requiring transfer to hospital and in patient monitoring due to medication administration. This was identified as a past non-compliance. Findings include: Review of facility policy titled Administering Medication dated April 2019 revealed 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record and c. if necessary, verifying resident identification with other facility personnel. Review of Resident R1's clinical record revealed diagnoses including Congestive Heart Failure (excessive body/lung fluid caused by a weakened heart muscle) and paroxysmal Atrial Fibrillation (irregular heart rhythm that starts and stops spontaneously). Review of Resident R1's clinical record revealed progress note dated March 21, 2026, (15:00 aka 3:00 p.m.) revealed Notified by LPN (Licensed Practical Nurse) that resident received the wrong medications. Resident assessed. Alert and oriented to person place situation and time. Resident states no pain, no blurred vision, or any new/onset symptoms. Vitals signs: temp 97.4 (normal temperature ranges 97.7 F to 99.5 F); bp (blood pressure) 105/58 (normal blood pressure range 120/80); hr (heart rate) 66 (normal heart rate ranges 60 to 100 beats per minute) and oxygen 91% (normal oxygen range 95%-100%). No noted allergies to medications administered. RP (Responsible Party) notified and updated on situation. CRNP (Certified Registered Nurse Practitioner) was notified of all medications resident received. At 1:08 p.m. CRNP stated to only give resident (his/her) eliquis (oral anticoagulant used to prevent and treat blood clots) and hold all other medications. When LPN was going to give resident (his/her) eliquis it was observed resident was slightly lethargic (drowsy, fatigued or having lack of energy). VS (Vital Signs) checked by RN (Registered Nurse) and resident assessed mental status. Vital signs: BP 85/50, temp 98 HR 70 RR 15 O2 92%. Resident alert and oriented to person, place, time, and situation. Resident still showing signs of lethargy. CRNP notified of drop in blood pressure. New order for vital signs q (every)15 minutes for 1 hour. Next vital sign set collected BP 78/52 and resident has increased lethargy. CRNP ordered to administer Narcan (medication used to reverse the effects of opioid overdose) at 1403 (aka 2:03 p.m.). CRNP called with update that resident continued to show signs of lethargy. Mental status assessed and resident unable to state where (he/she) was. Resident stated (he/she) was at the general, CRNP ordered to have resident sent out to be evaluated. 911 called at 1423 (aka 2:23 p.m.) to send resident to ED. EMS arrived to facility at 1440 (aka 2:40 p.m.) Resident left facility at 1457 (aka 2:57 p.m.) via litter with EMS (Emergency Medical Services) to hospital emergency department. RP notified of transfer. Resident sent with POLST (Physician Orders for Life- Sustaining Treatment), face sheet, transfer notification and bed hold. Further review of Resident R1 clinical record revealed medications received in error; Aspirin 325 mg (milligram) (medication to reduce pain, swelling, and/or fever); Xcopri 300 mg (medication used to treat seizures in adults); Aptiom 800mg (is a medication used to (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
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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 0760 Level of Harm - Actual harm Residents Affected - Few	treat and or prevent seizures); Levetiracetam 1500mg (medication used to treat seizures); Lorazepam 1mg (medication used to treat anxiety and insomnia); Morphine Sulphate 0.25 ml (milliliter) (medication used to treat moderate/severe pain); Acetaminophen 650 mg (medication used as pain reliever and/or fever reducer); Carbidopa-Levodopa 25 -100 mg two tablets (medication used to treat Parkison's disease a condition that affects the brain and causes symptoms such as shaking, stiffness and slow movement) and Gabapentin 600 mg (helps reduce pain and controls seizures). Review of Licensed Practical Nurse (LPN) Employee E3 written statement dated March 21, 2026, stated that When this writer entered room [ROOM NUMBER]. Writer called out (Resident R2) name and the B bed (Resident R1) said yes, help me, this writer asked the patient what did (he/she) need, patient said (he/she) wanted to be turn facing the door. This writer gave the patient (Resident R1's) medication. Review of documentation provided by the facility indicated LPN Employee E3 was suspended and will return to assignment once additional mentoring and a medication administration is completed. Review of Resident R1's hospital records dated March 21, 2026, revealed Resident R1 was admitted on [DATE]. Hospital record revealed under section Impression/Plan Accidental drug ingestion: pt (patient) residents at Susquehanna N&R (Nursing&Rehabilitation) and was accidentally given (his/her) roommates medications including Ativan (lorazepam), Keppra (levetiracetam), Gabapentin, Morphine, and Xcorpi with resultant lethargy and hypotension. Improving with Narcan, IVF (intravenous fluids) and time. Monitor Telemetry. May need additional fluids and reversal agents. Interview conducted with the Nursing Home Administrator on March 31, 2026, at 12:30pm confirmed the above findings. The facility self-identified the deficient practice at the time of the incident, March 21, 2026. The facility implemented a corrective action of education and medication pass audits. The facility's immediate action plan included the following: QAPI (Quality Assurance Performance Improvement) conducted March 21, 2026. Reviewed LPN Employee E3's file to ensure she had received education on Medication Administration prior to the incident. This was verified as completed on March 19, 2026. Evaluated all other residents on the same unit as Resident R1 who had received medication from Employee E3 to observe for adverse effects, which included obtaining vitals. This was verified and completed March 21, 2026. Education was initiated for all facility nursing on the policy of Medication Administration, which includes proper identification of residents prior to medication administration and documentation of medication administration. All nurses completed training by March 23, 2026. Education was completed on March 23, 2026, by the DON (Director of Nursing) with RN supervisor Employee E4 regarding notification of the DON for significant medication errors and the RN's ability to transfer a resident to the hospital when a significant change in condition is noted. Medication pass audits for competency will be completed by all current licensed nurses. This was verified and completed March 28, 2026. During an interview on March 31, 2026, at 10:20 a.m. LPN Employee E5 verified he received education on Medication Administration and was able to verbalize understanding. During an interview March 31, 2026, at 10:30a.m. RN Employee E6 verified that she had received education on Medication Administration and was able to verbalize understanding. During an interview on March 31, 2026, at 10:40 a.m. LPN Employee E7 verified that she had received education on Medication Administration and was able to verbalize understanding. She added that all residents have an updated picture in their chart, and that if you cannot identify the resident, you can ask another staff member. The facility has demonstrated compliance with the above since March 28, 2026.28 Pa Code 201.18(b)(1)(e)(1) Management28 Pa Code: 211.10 (c) Resident care policies