STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395403	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport Meadows Health and Rehabilitation Center	41 Newport Avenue Christiana, PA 17509

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** 41765 Based on review of clinical records, hospital records, and staff interviews, it was determined that the facility failed to ensure the physician medication orders were accurately entered and followed for one of four residents reviewed (Resident CL1). Findings include: Review of CL1's clinical records revealed Resident CL1 was admitted to the facility on [DATE], with a diagnosis of Epilepsy (abnormal movements due to unusual electrical activity in the brain), and Irritable Bowel Syndrome (IBS- disorder that affects the stomach and intestines). Review of Resident CL1's Hospital Discharge Summary, Medication List, revealed a list of the medications for the resident to take. The list includes an order for Prednisone (anti-inflammatory medication)10 mg. Take four tablets by mouth daily for five days, then three tablets daily for seven days, then two tablets daily for seven days, then one tablet daily for seven days. Start taking on May 19, 2024. Review of Resident CL1's physician's order dated May 18, 2024, revealed Prednisone 10 mg four tablets by mouth every five days until May 23, 2024; three tabs by mouth daily until May 31, 2024, two tablets by mouth every seven days until June 6, 2024, and one tablet by mouth once daily until June 15, 2024. Review of Resident CL1's May 2024, Medication Administration Record (MAR) revealed that the Prednisone 10 mg four tablets was transcribed to be given every five days instead of daily for five days which was the hospital's medication order sent to the facility. The MAR revealed that the Prednisone 10 mg four tablets was only administered on May 19, 2024, until the resident left the facility in the afternoon of May 21, 2024. (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
	395403	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport Meadows Health and Rehabilitation Center	41 Newport Avenue Christiana, PA 17509

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	Interview with the licensed nurse, Employee E3 conducted on June 13, 2024, revealed upon residents' admission, hospital medication orders were reviewed by the nursing supervisor with the physician. If the physician does not agree with the hospital medication order, a note is written in the medication list from the hospital or on the resident's medical record. Employee E3 then reported that upon the physician's approval of the medication list from the hospital, the nursing supervisor enters the order into the physician's order and will automatically be transcribed in the resident's medication administration record. Employee E3 confirmed that licensed nurse Employee E4 entered the Prednisone order in the physician's order but was unable to provide an answer as to why it was entered as every five days instead of daily for five days. Review of Resident CL1's clinical record failed to reveal documentation the physician wanted Prednisone 10 mg four tablets every five days instead of daily for five days which was the order from the hospital. The facility failed to ensure that the hospital medication order was accurately entered into the physician's order. Review of Resident CL1's physician order dated May 18, 2024, revealed an order for Mesalamine 800 mg given 1600 mg by mouth three times daily for IBS. The medication was scheduled to be administered at 12 midnight, 8:00 a.m., and 4:00 p.m. Review of May 2024, MAR revealed that Mesalamine medication was not administered from the midnight of May 19, 2024, until the midnight of May 21, 2024. Review of Resident CL1's clinical record revealed, Mesalamine medication was not administered due to the unavailability of the medication. Clinical records further revealed that the physician was notified of the missed medication from May 19, 2024, until midnight May 20, 2024. Clinical records review revealed physician was not notified that medication was still unavailable and therefore was missed on May 20, 2024, at 8:00 a.m., May 20, 2024, at 4:00 p.m., and May 21, 2024, at midnight. The above information was conveyed to the Nursing Home Administrator on June 13, 2024. The facility failed to ensure physician's order was accurately entered and followed. 28 Pa. Code 201.18(b)(1) Management 28 Pa. 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f) Clinical records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395403	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport Meadows Health and Rehabilitation Center	41 Newport Avenue Christiana, PA 17509

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41765 Based on a review of the facility's policy, observations, clinical record reviews, and staff interviews, it was determined the facility failed to ensure Enhanced Barrier Precautions (EBP-infection control prevention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) were in place for residents requiring enhanced barrier precautions for three of three residents reviewed (Residents R1, R2, and R3). Findings include: Review of the facility's policy titled Enhanced Barrier Precautions dated April 2024, revealed that EBP is indicated for residents with wounds and/or indwelling medical devices, regardless of MDRO (Multiple Drug Resistant Organism) infection or colonization status. Appropriate notification/signage is placed at the room entrance indicating the type of precaution and instruction for PPE (Personal Protective Equipment) use. PPE will be available to staff for donning before entering the resident's room. Observation conducted on June 13, 2024, at 11:00 a.m., revealed Resident R1 in bed with a dressing on the left foot. Review of Resident R1's clinical record revealed Resident R1 has a left heel ulcer. Review of Resident R2's clinical record revealed Resident R2 has a sacral pressure ulcer. Review of Resident R2's clinical records revealed Resident R3 has a left lateral foot wound. Observation of Resident R1, R2, and R3'2 room entrances revealed no signage for EBP and no PPEs. Interview conducted with licensed nurse, Employee E5 on June 13, 2024, confirmed Resident R1, R2, and R3 all have wounds. Employee E5 reported the staff had to request housekeeping to send PPEs to the unit if needed. The above information was discussed with the Nursing Home Administrator on June 13, 2024. The facility failed to ensure the EBP process was implemented for Resident R1, R2, and R3. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service