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	11/10/2024

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 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** 38419 Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to ensure that residents were free from significant medication error for one of three residents, resulting in Resident R1 needing emergency medical treatment (Resident R1). This situation was identified as past non compliance. Findings include: Review of facility policy titled Administering Medications revealed number nine indicating the following: 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. Further review of the facility policy revealed number ten which indicated: The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Review of Resident R1's clinical record revealed diagnoses including but not limited to the following: Dementia (loss of thinking, remembering, and thinking skills) Chronic Kidney Disease Stage 3 (gradual loss of kidney function); Cerebrovascular Disease (condition that affects blood flow to the brain); Psychotic Disorder with Delusions; and Depression (persistent feeling of loss and lack of interest in activities of daily living). Review of Resident R1's clinical record revealed a progress note dated October 13, 2024 (10:49 a.m.) Resident was mistakenly given (his/her) roommates medication which included carvedilol,lisinopril,clonidine and Keppra. [Resident's] BP/HR are low 74/40 and 42 [on call physician] returned the undersigned's call to the answering service and gave the directive for the resident to be sent to the hospital. [family member] contacted/apprised. (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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident R1's clinical record revealed a progress note dated October 13, 2024 (12:18 p.m.) indicating the undersigned mistakenly administered this residents' roommate's medications @ 0800, Resident was in the hallway sitting on a chair. After realizing this error @0900, the residents bp/HR (blood pressure/heart rate) was rechecked and was 72/40 HR42. Supervisor notified immediately. attempts to reach on-call @0910 Medications that were given are: Sinemet 25-100mg (medication used to treat Parkinson's disease), hydralazine HCl 100mg (medication used to treat high blood pressure), Carvedilol 25mg (medication used to treat high blood pressure), clonidine HCl 0. 1mg (used to treat high blood pressure), Keppra 750 mg (medication used to treat seizures), and Lisinopril 40mg (used to treat high blood pressure). resident is alert and oriented. On-call [physician] returned phone call to supervisor @ 10:28, and EMS (emergency medical service) was called. resident BP was continued to be monitored until MD instructions were received and EMS arrival, BP/HR fluctuated from 72/40 HR 46 to 74/38 HR 42 @ 10am, resident responded appropriately for situation. last set of BP/HR @1045 before EMT arrival was 74/38 HR46. POA (power of attorney) was notified. Review of Resident R1's hospital progress notes dated October 14, 2024 through October 17, 2024, revealed under section titled Assessment and Plan Acute Conditions indicated number of accidental medication administration, number two Bradycardia (slow heart rate) improving, and number three Hypotension resolved. Further review of Resident R1's hospital documentation revealed a progress note dated Ocober 16, 2024 by hospital physician noting history of HTN (Hypertension), who presented on 10/13/2024 after accidental medication administration at (his/her) skilled nursing facility - pt (patient) received ACEi (Angiotensin-converting enzyme (ACE) inhibitors are medicines that help relax the veins and arteries to lower blood pressure), hydralazine, clonidine, keprpa, sinemet, lisinopril that was meant for another patient. (He/she) arrived bradydcardic and hypertensive (high blood pressure of 180/120). (He/she) received glucagon for beta blocker reversal. admitted to ICU (Intensive Care Unit) for monitoring. Did require inotropic and vasopressor support. Weaned off of these interventions. Review of facility documentation titled Verification of Investigation revealed under section titled detailed description of event indicated, On 10/13/24 at approximately 0744 (7:44 a.m.), (Licensed Practical Nurse) asked [Resident R1] if (his/her) name was [NAME] and the (Resident R1) replied yes. LPN then administered (Resident R2) medication to (Resident R1). At approximately 0900 [Resident R1] stated that (he/she) did not feel well, and the LPN took the blood pressure of the (resident), and it was noted to be at approximately 72/40. The LPN went to the (resident's) room and noted that [Resident R2] was in (his/her) bed, and (Licensed nurse Employee E2) accidently gave the incorrect medications to the wrong (resident). Further review of facility documentation including section titled Assessment of resident/describe injury revealed the following: Assessment completed by RN (Registered Nurse) in house, VS (vital signs) taken and noted to have a change in condition. The (resident) laid flat and feet elevated, the fluids pushed. (Resident's) blood pressure remained low, (resident) remained conscious the entire time until the EMT (Emergency Medical Team) arrives and transported to the ER (emergency room). Additional review of facility documention titled Verification of Investigation revealed under section titled Summary and Outcome of Investigative findings the following: Employee (Licensed Employee E2) did not follow facility policy and will receive a final written warning. Employee will have 3 consecutive observations to ensure understanding of identifying residents prior to administering medications. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Further review of facility documents including Employee E2 (LPN [NAME])'s statement which revealed [Resident R1] was sitting in the hallway and the first thing I did was go around and take my parameters for blood pressure medications and when I asked [Resident R1]if his name was [NAME] (he/she) stated yes. So I took (his/her) BP (blood pressure) and it was 136/78 or so. Then I administered Resident R2's medication to Resident R1. Then about 45 minutes later [Resident R1] was still sitting in the hallway and then (he/she) said I don't feel very well so I rechecked (his/her) blood pressure because I knew that I gave (him/her) all those blood pressure medications, and (his/her) blood pressure was really low 72/40 or something and then I walked back to (his/her) room and I was like oh no (he/she) is in A bed, not B bed so I realized (employee E2) had the wrong patient. Then (Employee E2) notified the supervisor right away, I got (him/her) back in bed laying flat and (Employee E2) kept rechecking (his/her) blood pressure every 10-15 minutes, it was fluctuating up and down at the time. RN supervisor called the on call and came over to assessed the (resident) . The facility initiated a full sweep of all the residents to determine if any others received incorrect medications. The review of all residents did not reveal any other residents effected by the deficient practice. The facility began to provide education to all licensed staff regarding administration of medications including reeducation on proper medication administration policy and protocols. Review of education documentation revealed that education was completed on October 21, 2024. Interviews conducted with three licensed staff (Employee E3, E4, E5) on November 10, 2024 revealed education was provided regarding medication administration and ensuring proper identification of resident prior to administering medications. Interview conducted on November 10, 2024 at approximately 2:00 p.m. with the Director of Nursing confirmed that Resident R1 was given another resident's medications which resulted in the need for emergency medical intervention and hospitalization . The facility failed to ensure that Resident R1 was free of significant medication error when facility staff administered roommate's medications (Resident R2) to Resident R1 causing a physical decline and needing emergency intensive evaluation and treatment. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(e)(1) Management 28 Pa Code 201.18(b)(3)(e)(1) Management 28 Pa Code 211.12(c) Nursing services 28 Pa Code 211.12(d)(3) Nursing services