STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395432	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Center for Rehabilitation and Nursing	280 Middle Holland Road Holland, PA 18966

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 43923 Based on a review of the observations, and an interview with residents and staff, it was determined that the facility failed to ensure that the most recent Department of Health Survey results were readily accessible to residents and visitors in two of two nursing floors. (First Floor and Second Floor. Findings include: On May 13, 2025, at 11:52 a.m., a facility tour was conducted with the Director of Social Services, Employee E4 to observe the placement of the Department of Health Survey binder within the facility. During the tour of the first and second-floor nursing units, it was noted that the Department of Health Survey results binder was not readily accessible to residents or visitors, as it was placed behind the nursing station, requiring individuals to request access. Additionally, the binder on the second floor was outdated, with the most recent survey results dated January 22, 2019. During a resident council meeting held on March 14, 2025, at 10:30 a.m., with 4 residents (R27, R9, R140, R14), who were identified as alert and oriented, it was revealed that the residents were unaware of the recent Department of Health Survey results. 28 Pa. Code 201.14(a) Responsibility of licensee

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43923 Based on a review of facility policies and procedures, employee personnel records, and staff interviews, it was determined that the facility failed to develop and implement an abuse prohibition policy that required a thorough investigation of prospective employees' employment history for three of five newly hired employees reviewed. (Employees E8, E9, E10) Findings include: A review of the Facility Policy titled Abuse Prevention Program revised November 30, 2022, revealed our residents but is not limited to freedom from corporal punishment, involuntary seclusion, verbal mental and sexual or physical abuse, physical or chemical restrains to required to treat resident's symptoms. Under Policy Implementation bullet #2 it further states Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect exploitation, misappropriation of property, or exploitations mistreatment of residents or misappropriation of their property. A review of the Activity aide, Employee E8's personnel file revealed that Employee E8 was hired on January 22, 2025, and criminal background was not done until February 3, 2025. A review of the Nurse aide, Employee E9's personnel file revealed that Employee E9 was hired on January 13, 2025, and criminal background was not done until May 14, 2025. A review of the Registered Nurse, Employee E10's personnel file revealed that Employee E10 was hired on January 13, 2025, and criminal background was not done until March 24, 2025. An interview was conducted with Human Resources staff, Employee E14 on May 15, 2025, at 1:46 p.m., confirmed Employees E8, E9 and E10 had their criminal background done after their hire date. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility did not ensure that allegations of abuse and neglect was reported immediately to the Pennsylvania Department of Health for one of four residents reviewed. (Resident R143) Findings Include: A review of the Facility Policy titled Abuse Prevention Program revised November 30, 2022, revealed our residents but is not limited to freedom from corporal punishment, involuntary seclusion, verbal mental and sexual or physical abuse, physical or chemical restrains to required to treat resident's symptoms. Under Policy Implementation bullet #2 it further states Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect exploitation, misappropriation of property, or exploitations mistreatment of residents or misappropriation of their property. Review of Resident R143's clinical record revealed that the resident was admitted to the facility on [DATE]. The resident had the following diagnoses: dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, need assistance for personal care. Review of facility's internal investigation statement dated July 16, 2024, at 6:20 p.m. revealed a nursing aide, Employee E17 stated Yesterday at 2:50 p.m. [Resident R143] started acting up in the hallway. She pulled her pants down and started to pee in the hallway. [Nurse aide, Employee E16] and [Nurse aide, Employee E18] were trying to get the resident in the room (xxx). I was walking up to help assist them. The resident door was open , [Employee E16] had a clean diaper in her hand and [the Resident R143] took the diaper out of [Employee E16] and slapped her against the face. Employee E16 grabbed it back and slapped the Resident R143 across her face. Who did you report it to? I told nurse supervisor, Employee E19 today, because when this happened the shift was over, and I went home. That's why I told E19 today. On May 14, 2025, at 2:13 p.m. an interview with the Administrator, Employee E1 and Director of Nursing, Employee E2 confirmed that nursing aid, Employee E17 failed to report an allegation of abuse immediately after the incident accrued. The incident occurred on July 15, 2024, at approximately 2:50 p.m. and nursing aide, Employee E17 reported to the nursing supervisor, Employee E19 on July 16, 2024, at 3:00 p.m. Shift Scheduled were confirmed for evening (3:00 p.m. -11:00 p.m.) shift of July 15 going into night (11:00 p.m. -7:00 a.m.) shift of July 16, 2024, that nursing aids Employee E16, E17, E18 did not work any double shifts and were all suspended after the allegation was reported on July 16, 2024, at 3:00 p.m. The facility's staff failed to immediately report an allegation of abuse, which delayed the initiation of an internal investigation by approximately 24 hours, the immediate suspension of the alleged perpetrators, and notification to the State Licensing Agency. 28 Pa. Code: 201.14(a)(c) Responsibility of licensee. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.18(b)(1)(e)(1) Management.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of facility policy and review of clinical records, it was determined that the facility failed to develop and implement a baseline care plan for one of two clinical records reviewed (Resident R140). Findings Include: Review of facility policy, Care Plan, Comprehensive Person-Centered revised March 2022, revealed, A comprehensive, personal -centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of Resident 140's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of severe protein-calorie malnutrition, anorexia (eating disorder that involves severe calorie restriction), depression (loss of interest in pleasurable activities), muscle weakness. On May 13, 2025, at 12:13 p.m. an interview was held with Resident 140 who reported I lost a lot of weight. Review of Resident R140's clinical record revealed no documented evidence a baseline care plan was developed and implemented related to the resident's nutrition diagnosis. On May 14, 2025, at 1:35 p.m. an interview with the Director of Nursing, Employee E2 confirmed that Resident R140 did not have a baseline care plan developed related to nutrition. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of facility policy, review of clinical records, observations, and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for three of twelve residents reviewed (Residents R29, R4 and R188). Findings include: Review of facility policy, Care Plan, Comprehensive Person-Centered revised March 2022, revealed, a comprehensive, personal -centered care plan that includes measurable objectives and timetables to [NAME] the resident's physical, psychosocial and functional needs is developed and implemented for each resident and services not provided due to the resident exercising their right to refuse treatment. A review of the clinical record for Resident R4 revealed an admitted [DATE], with diagnoses including chronic pulmonary disease (disease process that causes decreased ability of the lungs toperform), respiratory failure with hypoxia (low levels of oxygen). Review of Resident R4's physician orders dated May 11, 2025, for change nebulizer mask and tubing weekly; date and place in dated plastic bag. Place in date bag when not in use. On May 13, 2025, at 11:11 a.m., an observation and interview were conducted with Resident R4 who reported that his nebulizer is at bedside; however, as of today it stopped nursing staff were aware. A review of the comprehensive care plan dated, April 2, 2025, did not have a care plan related to nebulizer treatments. On May 13, 2025, at 11:42 a.m. a assistant director of nursing, Employee E3 confirmed that Resident R4 did not have a care plan related to nebulizer treatments. Review of Resident R29's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease (Parkinson's disease is a progressive neurological disorder characterized by the degeneration of brain cells that produce dopamine, a neurotransmitter essential for motor control. This leads to a variety of motor symptoms, including tremors, stiffness, slowness of movement, and balance problems. Additionally, non-motor symptoms like depression, anxiety, and sleep disturbances can also occur), and Syncope and Collapse (Syncope, commonly known as fainting, is a brief loss of consciousness accompanied by a loss of postural tone due to reduced blood flow to the brain). Review of physician order for Resident R29, dated April 14, 2025, indicated an order to administer Oxygen Continuous at 2 Liters. Another order of the same date indicated an order to administer Oxygen as needed. Review of the care plan for Resident R29, on May 15, 2025, at 11:16 a.m., revealed that there were no focus, interventions, and outcomes (goals) care- planned for oxygen administration. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 15, 2025, at 11:19 a.m., interview with Employee E13, a Registered Nurse confirmed the above findings. Review of Resident R188's admission MDS (minimum Data Set, an assessment of residents' needs) dated December 31, 2024, indicated the resident was admitted with pressure ulcers and was at risk for further injury. Review of Resident R188's physician order, ordered PR boots (to elevate heels) be worn while the resident was in bed Interview with Resident R188 on May 13, 2025, at 2:00 p.m. observed the resident not wearing the boots while in bed and the resident stated the resident does not wear them. Review of documentation from the wound team documented Resident R188 was noncompliant with the boots. Review of the treatment administration record revealed the resident was documented compliant and marked as wearing the boots. Review of Resident R188's care plan failed to develop a care plan for boots worn to reduce pressure injury and/or resident's noncompliant with care. 28 Pa Code 211.10 (c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for two of 12 residents reviewed (Residents R4, R29). Findings include: Review of the Facility Policy and Guidelines for implementation of Oxygen administration indicated that the nurse should review and follow the physician's orders while administering Oxygen via nasal canula. Review of Resident R29's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease (Parkinson's disease is a progressive neurological disorder characterized by the degeneration of brain cells that produce dopamine, a neurotransmitter essential for motor control. This leads to a variety of motor symptoms, including tremors, stiffness, slowness of movement, and balance problems. Additionally, non-motor symptoms like depression, anxiety, and sleep disturbances can also occur), and Syncope and Collapse (Syncope, commonly known as fainting, is a brief loss of consciousness accompanied by a loss of postural tone due to reduced blood flow to the brain). Review of physician order for Resident R29, dated April 14, 2025, indicated an order to administer Oxygen Continuous at 2 Liters. Another order of the same date indicated an order to administer Oxygen as needed. In May 2025, at 11:09 a.m., observed Resident R29, and that no oxygen administered as ordered. Registered Nurse, E13 confirmed the finding at the time of the observation. A review of the clinical record for Resident R4 revealed an admitted [DATE], with diagnoses including chronic pulmonary disease (disease process that causes decreased ability of the lungs to perform), and respiratory failure with hypoxia (low levels of oxygen in the body tissue) . Review of Resident R4's physician orders dated July 18, 2024, for O2 at 3 liter/minute via nasal cannula continuously for chronic obstructive pulmonary disease. On May 13, 2025, at 11:11 a.m., an observation and interview were conducted with Resident R4, revealed 2 liter of oxygen flow rate. The oxygen consecrator had a dirty filter and oxygen tubing was labeled with a bandage only readable label 11-7 shift. On May 13, 2025, at 11:24 a.m., the above observations were confirmed by Licensed Nurse, Employee E6. The labeling on the tubing was unreadable; therefore, Employee E6 decided to replace the entire tubing, increased the resident's oxygen flow to 3 liters, and confirmed that the filter on the back of the oxygen concentrator was dirty. 28 Pa Code 211.12(d)(5) Nursing services

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 43923 Based on a review of employee personnel records and staff interviews, it was determined that the facility failed to complete performance reviews for nurse aides in one out of the two employee personnel records reviewed. (Employee E12) Findings include: Record review of personnel file for Employee E12 revealed that employee was hired by the facility on March 23, 2024 as a nurse aide. There was no further documentation available in the record to demonstrate that a skills evaluation or post orientation performance evaluation had been completed. Interview on May 16, 2025 at 10:44 a.m. with the Director of Nursing revealed that the facility does not complete competencies or performance reviews on staff and confirmed that Employee E12 does not have a completed performance review on file. Continued interview with the Director of Nursing revealed that the facility does not have a policy or procedure related to staff competencies or performance reviews and stated that none of the nurse aides have annual performance reviews completed. 28 Pa. Code 201.19 Personnel policies and procedures

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on clinical record review, staff interview and review of facility policy, it was determined that the facility failed to to ensure that nursing staff was informed of a resident with a diagnosis of PTSD (Post traumatic Stress Disorder) to ensure treatment and services for one of one resident review with PTSD. (Resident R4) Findings include: A review of the facility policy titled, Trauma-Informed Care undated, reveals This policy establishes guidelines for implementing trauma-informed care (TIC) in the long-term care facility to support residents and staff who may have experienced trauma. The goal is to provide care that is safe, respectful, and responsive to the effects of trauma while fostering a supportive environment. Rreview of Resident R4's clinical record revealed that the resident was admitted to the facility on [DATE]. Continued review of the resident's clinical record revealed a psychological notes completed by Nurse Practitioner , Employee E7 on March 27, 2025, and May 1, 2025, which documented that [Resident R4] has PTSD symptoms, including nightmares several times per month. Resident states he tolerates the nightmares and is not seeking any treatment for them. The PTSD diagnosis was listed under the Other Diagnoses category in the progress notes on both dates. On May 15, 2025, at 11:57 a.m., an interview was conducted with Registered Nurse, Employee E15, who stated he was unaware that Resident R4 had a PTSD diagnosis. Employee E15 explained that he is typically responsible for assessing residents by reviewing hospital records, identifying active diagnoses, and developing comprehensive care plans. In this instance, the psychological progress notes indicating PTSD were not communicated to him. On May 16, 2025, at approximately 9:30 a.m., an interview was conducted with the Director of Nursing, Employee E2 and the Administrator, Employee E2, who confirmed that Resident R4 is a veteran. They further stated that they were not aware of the PTSD diagnosis or related symptoms. It was also acknowledged that there was no established communication system in place for the psychologist to report new resident diagnoses to the facility's staff. 28 Pa Code 211.12 (d)(1) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of clinical records and interviews with staff, it was determined the facility failed to acquire, receive and administer medications to a newly admitted resident for one of 12 resident records reviewed (Resident 190). Findings include: Review of Resident R190's nursing note revealed that the resident was admitted to the facility on [DATE], at 11:52 a.m. from the hospital, with a diagnosis of traumatic subdural hematoma due to a fall prior to admission. Resident R190 was alert and oriented, capable of making their own decisions. Continued review of nursing notes indicated Writer reviewed and provided a copy of all of physician orders including medication administration and treatment administration records to resident. Resident reviewed and is agreeable with and received a copy of baseline and discharge plan of care. On March 1, 2025 the electronic medication administration record (EMAR) noted Heparin Sodium (Porcine) Injection Solution 5000 UNIT/ML instructed to inject 50000 unit subcutaneously two times a day for deep vein thrombosis, (blood clot) prophylaxis, Dronabinol Oral Capsule 2.5 milligrams (mg) taken two times a day for nausea, Modafinil Oral Tablet 200 mg, given one tablet by mouth two times a day for Sleep apnea (a serious sleep disorder where breathing repeatedly stops and starts during sleep), was not administered. The nurse noted the reason why the medication was not administered was due to the resident being a new admit (admission) and that the medication on order from pharmacy. On March 2, 2025, at approximately 10:00 a.m., the EMAR noted Dronabinol Oral Capsule 2.5 mg , Modafinil 200 mg, and Mekinist Oral 2 mg given one tablet a day for cancer was not administered with the morning medications due to the medication not being available. On March 3, 2025 at 4:00 p.m. nursing note indicated the script for modafinil and dronabinol were faxed to the pharmacy. At approximately 11:00 p.m. EMAR note indicated both medications were not available and were still waiting on the pharmacy to deliver them. March 4, 2025 at approximately 1:00 p.m. indicated dronabinol and modafinil were still not available. That same day the physician progress note noted Resident R190's poor intake and nausea and stated to continue taking dronabinol. At 11:00 p.m. EMAR progress note noted dronabinol and Modafinil had still not been received from pharmacy and again on March 5, 2025 at approximately 10:00 a.m. and 9:00 p.m. Further review of the clinical record revealed no evidence the physician was aware medications were still not available from the pharmacy. Physician progress not dated March 6, 2025 noted to continue modafinil for neuro stimulation and due to Resident R190 poor intake, continue taking dronabinol. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on May 16, 2025, at 11:00 a.m. with the Director of Nursing indicated the facility does not have a policy or a procedure that is followed that ensures residents receive their prescribed medication nor a protocol that is followed when medications are not available from the pharmacy nor if the medication is not administered. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36609 Based on observations, review of clinical records, and interviews with facility staff, and facility policy it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for one of four residents observed during medication administration (Residents R29), and failed to administer medications in a timely manner, and as ordered by the physician for one of 12 resident records reviewed (Resident R188). Findings include: Review of the facility's policy titled, Administering Medications revised on April 2020 states medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit not staff convenience. Medications are administered within one hour of prescribed time, if a dosage is believed to be inappropriate or excessive for a resident the person preparing or administering the medication will contact the prescriber. Resident R188 was initially admitted to the facility December 28, 2024, with diagnoses that included fibromyalgia, chronic pain, heart disease, obstructive pulmonary disease (Lung disease) , and Type 2 Diabetes mellitus (body cannot produce insulin). Interview with Resident R188 on May 13, 2025, at 2:00 p.m. stated the nurse was late administering the resident's medication January 1, 2025. I didn't get any of my morning meds until noon. I started getting shooting pain in my feet because I didn't have my gabapentin. Review of Resident R188 physician orders for January 1, 2025, revealed an order for Gabapentin oral tablets 600 mg 1 tablet given four times a day for neuropathy (nerve pain), scheduled to be given at., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. Review of the facility's medication audit report received from the Director of Nursing, revealed 8:00 a.m. dose was not given until 12:31 p.m., (4 1/2 hours late), 12:00 p.m. dose was not given until 2:36 p.m., (over 2 1/2 hours late), , 4:00 p.m. dose was not given until 5:18 p.m. and the 8:00 p.m. dose was not given until 10:32 p.m. Lidocaine external patch 4% lidocaine for the resident's low back pain was to be applied at 9:00 a.m. but documented it was applied at 12:33 p.m Metformin HCl oral tablets 1000 mg was to give 1 tablet two times a day at 9:00 a.m., and 5:00 p.m. given with meals for the resident's diagnosis of Diabetes. The audit revealed the 9:00 a.m. dose was not administered until 12:34 p.m., and the 5:00 p.m. dose was administered at 5:18 p.m., almost 5 hours since last dose not 8 hours as ordered. It was confirmed by the Director of Nursing there was no evidence the physician was notified, nor orders allowing the medications to be given sooner than the expected time frame Review of physician orders for Resident R29, indicated orders dated January 9, 2025, for Metoprolol Succinate Extended-Release (ER) Oral Tablet 24 Hour 25 MG (milligrams), give 0.5 tablet by mouth one time a day for Hypertension (high blood pressure); Finasteride Oral Tablet 5 MG, give 1 tablet by mouth one time a day for BPH (condition where the prostate gland, located below the bladder in men, enlarges); Clopidogrel Bisulfate Oral Tablet 75 MG, give 1 tablet by mouth one time a day for AFib. (condition where the upper chambers of the heart (atria) beat irregularly and rapidly) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395432	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Center for Rehabilitation and Nursing	280 Middle Holland Road Holland, PA 18966

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations conducted on May 15, 2025, at 9:01 a.m., revealed Employee E13, a Registered Nurse, decanted Metoprolol Succinate ER Oral Tablet Extended Release 12.5 MG, Finasteride Oral Tablet 5 MG, and Clopidogrel Bisulfate Oral Tablet 75 MG, with other medications as ordered, into a Tablet Crusher Pouch, and was initiating to crush the medications, before administering it to Resident R29; but Employee E13 was prevented from crushing those three medications, as those medications should be administered whole. Review of literature revealed as follows: Metoprolol Succinate ER (Extended-Release) oral tablets should not be crushed, broken, or chewed because it can disrupt the extended-release mechanism, potentially leading to a rapid release of the medication and an increased risk of side effects. Metoprolol Succinate ER tablets are designed to release the medication slowly over a prolonged period, usually 24 hours, to provide a consistent therapeutic effect. A rapid release of metoprolol can result in higher than intended blood levels, potentially leading to an overdose and increasing the risk of side effects, such as dizziness, fatigue, and low blood pressure. Finasteride Oral Tablets are coated and will prevent contact with the active ingredient during normal handling, provided that the tablets are not broken or crushed. Clopidogrel Bisulfate oral tablets, should not be crushed because this can lead to a rapid and higher concentration of the drug in the body, potentially increasing the risk of bleeding. At the time of the observation, interview with Employee E13, confirmed the above findings. The facility incurred a medication error rate of 12.00%. . 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services