STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395483	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Markley Rehabilitation and Healthcare Center	550 East Fornance Street Norristown, PA 19401

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation, review of clinical records, and staff interviews it was determined the facility failed to ensure residents were free from significant medication errors for three of five residents reviewed (Resident R1, R2, and R3).Findings Include:Review of undated facility policy Administering Medications revealed medications should be administered in a safe and timely manner, and as prescribed. The individual administering the medication checks the label three times to verify the right resident, right medication, and right dosage before giving the medication. The individual administering medications should verify the resident's identity before giving the resident his/her medication.Review of Resident R1's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated August 31, 2025, revealed the resident was admitted to the facility on [DATE], assessed as cognitively intact, and had diagnoses of atrial fibrillation (irregular heart rhythm), anxiety (definition) and depression (definition).Review of Resident R1's clinical record revealed a physician order dated September 25, 2025, to administer oxybutynin chloride table 5 milligrams (mg) two times a day for bladder spams. The medication was scheduled to be given at 8:00 a.m. and 4:00 p.m. daily. Review of Resident R2's comprehensive MDS dated [DATE], revealed the resident was admitted to the facility on [DATE], assessed as cognitively intact, and had diagnoses of heart failure, hypertension (high blood pressure), renal insufficiency (impaired kidney function), diabetes mellitus (persistently high levels of sugar in the blood), hyperkalemia (high potassium levels in the blood), anxiety, and depression. Review of Resident R2's clinical record revealed physician orders effective September 28, 2025, including, but not limited to, Coreg oral tablet 25 mg two times per day (used to treat hypertension), hydralazine 50 mg three times per day (used to treat hypertension), allopurinol oral tablet 100 mg daily (used to treat gout), and losartan potassium 100 mg daily (used to treat high blood pressure and reduce risk of stroke). Review of Resident R2's clinical record revealed a nursing note dated September 29, 2025, that the physician assistant was made aware that the resident received a one-time dose of oxybutynin. Review of facility documentation revealed on September 28, 2025, at approximately 5:00 p.m. licensed nurse, Employee E3, pre-poured medications into small cups for roommates, Resident R1 and Resident R2. Licensed nurse, Employee E3, entered the room with both cups and provided Resident R2 with the medication cup that were intended for Resident R1. After taking the medication, Resident R2 realized the name on the cup of medication was for Resident R1. The medication was identified as oxybutynin chloride 5 mg. Review of statement by licensed nurse, Employee E3, dated September 29, 2025, confirmed Resident R2 was given the medication that was prescribed/intended for Resident R1. The medication was identified as oxybutynin chloride 5 mg.Continued review of Resident R1's clinical record revealed a physician order dated September 1, 2025, for Spiriva 10 micrograms (mcg) via inhalation daily (medication that relaxes muscles in the airways and increases air flow to the lungs). Further review of Resident R1's clinical record revealed a nursing note dated November 8, 2025, that indicated he/she received Spiriva orally instead of via inhalation.Interview on November 20, 2025, at approximately 10:30 a.m. with the Director of Nursing, Employee E2, revealed Spiriva 10 mcg is a small pill that gets inserted into the cartridge of the inhaler and inhaled through the device. Review of facility documentation revealed on November 8, 2025, Resident R1 reported to his/her nurse that on November 7, 2025, the licensed nurse, identified as Employee E3, gave Resident R1 an unfamiliar pill during morning medication pass. Review of Resident R1's statement revealed he/she questioned the medication but was told by licensed nurse, Employee E3, that it was his/her Spiriva and that it was going to be given in an oral pill form versus through the inhaler. Review of statement by licensed nurse, Employee E3, confirmed on November 8, 2025, this nurse went to give Resident R1 medications for the morning medication pass. Licensed nurse, Employee E3, subsequently gave Spiriva medication by mouth and did not have Resident R1 inhale it. Review of Resident R3's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). Continued review of Resident R3's clinical record revealed physician orders dated November 8, 2025, for Keppra and Lacosamide (anticonvulsant medications used to treat various types of seizures) to be given two times per day. The start date for both medications was November 9, 2025. Review of the facility's November 2025 grievance log revealed a grievance was submitted on November 12, 2025, by the family of Resident R3 related to a medication issue. The grievance alleged that Resident R3 did not receive his/her seizure