STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395735	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifequest Nursing Center	2450 John Fries Highway Quakertown, PA 18951

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on clinical record review, and resident and staff interview, it was determined that the facility failed to provide adequate and timely podiatry care for one of 19 sampled residents. (Resident 21) Findings include: Clinical record review revealed that Resident 21 was admitted to the facility on [DATE], with diagnoses that included spastic hemiplegia, (paralysis), cerebral palsy and muscle weakness. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert and oriented. On April 19, 2024, a social worker noted that the resident was alert, oriented and able to be understood at all times. In an interview on May 7, 2024, at 11:17 a.m., Resident 21 stated that he wanted his toe nails cut and that he had not received any kind of foot care from a podiatrist since he had been admitted to the facility. Further review of the clinical record revealed that there was no documented evidence that he had been seen by a podiatrist since he had been admitted to the facility. In an interview on May 9, 2024, at 9:29 a.m., the Administrator confirmed that the resident had not been scheduled for any of the monthly podiatrist's visits since he had been admitted to the facility. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that pharmacy recommendations were obtained and acted upon in a timely manner for two of 19 sampled residents. (Residents 10, 85) Findings include: Review of the facility policy entitled Medication Regimen Reviews, last reviewed January 9, 2024, revealed that the consultant pharmacist was to perform a medication regimen review (MRR) for every resident in the facility who was receiving medication. The consultant pharmacist was to provide a written report to the facility and attending physicians for each resident identifed as having a medication irregularity. An irregularity referred to the use of medication that was inconsistent with accepted pharmaceutical services standards of practice. The physician was to document in the medical record that the irregularity had been reviewed and what action was taken to address it. Clinical record review revealed that Resident 10 had a diagnosis of dementia and was care planned for the use of anti-psychotic medications. On November 3, 2023, a physician ordered an anti-psychotic medication (Seroquel) at night for generalized anxiety disorder. On January 26, 2024, a licensed pharmacist indicated that the diagnosis of generalized anxiety disorder was not a typical diagnosis to justify the use of an anti-psychotic medication. The pharmacist recommended to consider choosing a diagnosis that was considered appropriate for the use of the Seroquel. On February 2, 2024, a physician acknowledged the MRR and indicated that the diagnosis was to be psychosis for the continued use of the Seroquel. There was no documented evidence that the diagnosis for the continued use of the Seroquel was changed on the physician's order as recommended by the pharmacist. Clinical record review revealed that Resident 85 was admitted to the facility on [DATE], and was care planned for the use of an anti-psychotic medication. On October 31, 2023, a physician ordered an anti-psychotic medication (Seroquel) every day for behaviors. On November 20, 2023, a physician ordered an additional dose of the Seroquel at night for behaviors. On January 26, 2024, a licensed pharmacist indicated that the resident was receiving the Seroquel but lacked an allowable diagnosis to support the continued use of the anti-psychotic medication. The pharmacist recommended that the diagnosis of depression with psychotic features be used to justify the continued use of the Seroquel. On February 6, 2029, a physician acknowledged the MRR, but failed to include a response to the recommendation. There was no documented evidence that the diagnosis for the continued use of the Seroquel was changed on the physician's order as recommended by the pharmacist. In an interview on May 9, 2024, at 11:00 a.m., the Director of Nursing stated that the diagnosis had not been changed to reflect the pharmacist recommendation for the continued use of the Seroquel for Resident 10 and 85. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa.Code 201.18(e)(1)(3) Management. 28 Pa. Code 211.9(k) Pharmacy services. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 17709 Based on clinical record review and staff interview, it was determined that the facility failed to document the rationale and justification for the continued use of as needed (PRN) psychotropic medications for four of five residents sampled who had orders for anti-psychotic medications. (Residents 4, 10, 16, 77) Findings include: Clinical record review revealed that Resident 4 had diagnoses that included dementia and had a physician's order dated October 2, 2023, for staff to administer a psychotropic medication lLorazepam) every four hours PRN for anxiety. The current order for the lorazepam failed to include a time frame for the continued use of the PRN medication. There was no physician documentation that it was appropriate for the order to be extended beyond 14 days. Review of the Medication Administration Records (MARs) for March, April, and May 2024, revealed the PRN medication was administered three times. Clinical record review revealed that Resident 10 a had diagnosis of dementia. On October 31, 2023, a physician ordered for staff to administer an anti-anxiety medication (ativan) every six hours PRN for anxiety. The current order for the ativan failed to include a time frame for the continued use of the PRN medication. There was no physician documentation that it was appropriate for the order to be extended beyond 14 days. Review of the MAR for April 2024, revealed that the PRN medication was administered one time. Clinical record review revealed that Resident 16 had diagnoses that included major depressive disorder and anxiety and had a physician's order dated March 29, 2024, for staff to administer a psychotropic medication (trazodone) PRN at night for insomnia. The current order for trazodone failed to include a time frame for the continued use of the medication. There was no physician documention that it was appropriate for the order to be extended beyond 14 days. Clinical record review revealed that Resident 77 had a diagnosis of Alzheimer's disease. On October 10, 2023, a physican ordered for staff to administer an anti-anxiety medication (ativan) every six hours PRN for agitation/restlessness. The current order for the Ativan failed to include a time frame for the continued use of the PRN medication. There was no physician documentation that it was appropriate for the order to be extended beyond the 14 days. Review of the MARs revealed that the PRN medication was given two times in December 2023 and two times in January 2024. Further review of the MARs revealed that the PRN medication was given eight times in February 2024, nine times in March 2024, and three times in April 2024. In an interview on May 9, 2024, at 9:30 a.m., the Director of Nursing confirmed that there was no time frame for the continued use of the previously mentioned PRN psychotropic medications in Residents 4, 10, 16, and 77. 28 Pa. Code 211.12(d)(1)(5) Nursing services.