STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395791	A. Building B. Wing	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harston Hall LLC	350 Haws Lane Flourtown, PA 19031

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** Based on review of facility policy, review of resident clinical records, and interview with resident and staff, it was determined the facility fail to ensure physician orders were followed related to the administration an anticoagulant medication for one of 12 residents reviewed. (Resident R1)Findings include: Review a facility policy titled Reconciliation of Medication on admission revised July 2017, revealed the purpose of this procedure is to ensure medication safety by accurately accounting for a residence medication, including drug names, dosages, roots, and frequencies, upon emission or remission to the facility. Proper medication reconciliation is essential to prevent unintended omissions, duplications, or dosing errors that may occur during transitions of care. Medication and reconciliation involve comparing the medications a resident was taking prior to admission with those ordered upon admission. This comparison must include both prescription and over the counter medications and should reflect an accurate and complete list that specifies the drug name, dosage, root, frequency, and the indication for each medication. To complete this process staff must gather necessary documentation including the medication reconciliation form, the discharge summary from the referring facility, the emission order sheet, and any prescription or supplement information provided by the resident or their families during the medication history interview. For readmission, the most recent Medication Administration Record (MAR) should also be reviewed. Once all sources have been collected, the staff should compile a complete list of medications from the discharge summary, medication history, previous MAR (if applicable) and admission orders. Each medication should be listed with the corresponding dosage, root, frequency, and reason for use. Compiled list must be carefully reviewed to identify any discrepancies such as missing medications, changes in dosage, or differences in root or frequency. All findings, actions taken, and communication with providers must be clearly documented to ensure continuity of care and to support safe medication practice throughout the residence day in the facility. Review of Resident R1's Minimum Data Set (MDS-resident assessment) dated September 30, 2025, revealed Resident R1 was admitted to the facility on [DATE], with a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Continue review of Resident R1's clinical record revealed the resident's diagnoses of peripheral vascular disease vascular disease (disorders that affect the blood vessels outside of the heart and brain), chronic heart failure (heart failure often just called CHF happens when the heart can't pump blood effectively this can lead to a fluid buildup in the lungs and other parts of the body) ,acute ischemic heart disease (a sudden reduction in blood flow to the heart muscle often caused by a blockage in the coronary arteries, Coronary artery disease (blood vessels that supply the heart with blood become narrowed or blocked this usually happens due to the build up of plaque), cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), endocarditis (an infection of the inner lining of the heart usually involving the heart valves, and anxiety (a feeling of worry nervousness or unease often about an imminent). Review of Resident R1's July, 2025 through September 2025 physician orders revealed that the resident was order the anticoagulant medication Eliquis (Apixaban) 5 mg to be administered twice daily. Review of the resident's Medication Administration Record (MAR) revealed that the resident had an order to hold (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
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Eliquis for an upcoming surgery on July 14, 2025. Continue review of MAR's from July-September 2025 revealed that on July 14, 2025 was the last day the resident received Eliquis 5mg. The next administration of the medication Eliquis until September 26, 2025. Review of the hospital discharge orders for the following dates revealed that the resident was to continue the medication Eliquis as follows:7/22/25: Discharge orders indicated the resident was to continue Eliquis.8/4/25: Discharge orders specified Eliquis 5 mg to be continued.9/26/25: Discharge orders indicated Eliquis 5 mg twice daily. Interview with Director of Nursing, Employee E2 on October 3, 2025, at 2:10 p.m. confirmed that the medication Eliquis had not been administered to the resident for approximately nine weeks. Employee E2 stated that, to her knowledge, the medication was discontinued prior to the resident's surgery on July 17, 2025 and was never re-entered into the electronic health record or reordered thereafter. Interview with. Licensed nurse, Employee E3 on October 6, 2025, acknowledged it was her responsibility to verify all medications post-hospitalization, but the order for Eliquis was unintentionally missed. She further explained that standard protocol involves confirming medications with hospital staff during discharge and again upon the resident's return. 28 Pa Code 211.12(c)(d)1) Nursing services