STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395847	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Subacute and Respiratory Center	251 Stenton Avenue Plymouth Meeting, PA 19462

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review, facility policy, and staff interview, it was determined that the facility failed to ensure that residents medication regimen was free from unnecessary psychotropic medication for two of seven residents reviewed for unnecessary medications (Residents R1, and R47). Findings include: Review of facility policy titled Psychotropic Medication Use (revised 2024), revealed psychotropic medications is any medication that affects brain activity associated with mental processes and behavior. Psychotropic medications are not prescribed or administered on a PRN (as needed) basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are not antipsychotics: if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order. Clinical record review revealed Resident R1 was admitted to the facility November 15, 2024 with a diagnosis that included chronic respiratory failure, multiple sclerosis (breakdown of the protective covering of nerves), and cognitive communication deficit. Review of Resident R1's physician's order, dated March 25, 2025, revealed an order for Clonazepam (psychotropic anti-anxiety medication) 1 mg (milligram) every 24 hours as needed for anxiety/insomnia. Give PRN at bedtime. Further review of physician's order for Clonazepam 1 mg revealed a stop date of indefinite. Review of Resident R1's clinical record revealed physician's order for PRN Clonazepam 1 mg was ordered for anxiety/insomnia. Resident R1 had no documented diagnosis for anxiety/insomnia. Clinical record review revealed Resident R47 was admitted to the facility November 18, 2024 with a diagnosis that included chronic respiratory failure, anoxic brain damage (brain is deprived by oxygen), and dysphagia. Review of Resident R47's physician's order, dated April 14, 2025, revealed an order for Ativan (psychotropic anti-anxiety medication) 0.5 mg every 8 hours as needed for teeth grinding. Further review of physician's order for Ativan 0.5 mg revealed a stop date of indefinite. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R47's clinical record revealed physician's order for as needed Ativan 0.5 mg was ordered for teeth grinding. Resident R47 had no documented diagnosis for teeth grinding. The facility failed to ensure psychotropic medication was used to treat a specific condition as diagnosed and documented in the clinical record and failed to ensure as needed psychotropic medication was limited to 14 days or a clinical rationale for continuing beyond 14 days. 28 Pa. Code 211.2(d)(3) Medical director 28 Pa. Code 211.12(d)(1)(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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on review of clinical records, facility documentation, and staff interviews, it was determined that the facility failed to administer pain medication in accordance with physician orders for two of four residents reviewed for pain management (Residents R11, and R29). Findings include: Review of facility policy titled Pain Assessment and Management, revised 2025, stated pain is a multidisciplinary process that includes the following: developing and implementing approaches to pain management based on accepted standards of practice. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications. Clinical record review revealed Resident R11 was admitted to the facility December 20, 2018 with a diagnosis that included chronic repository failure, anoxic brain damage (brain is deprived of oxygen), and pain. Review of Resident R11's physician's order, dated April 09, 2025, revealed an order for Oxycodone (opiod for moderate to severe pain) 2.5 mg (milligrams) every 8 hours as needed for moderate to severe pain for pain level of 7-10 (on a pain scale of 1-10 with 1 being the least pain and 10 the most severe pain). Review of two months of Resident R11's medication administration record revealed Oxycodone 2.5 mg was administered for the following pain levels: -April 18, 2025 at 10:22 a.m. pain level of 6. -April 21, 2024 at 2:20 p.m. pain level of 5. -April 22, 2025 at 11:00 a.m. pain level of 5. -April 25, 2025 at 11:24 a.m. pain level of 5. -May 1, 2025 at 1:00 p.m. pain level of 6. -May 06, 2025 at 1:53 a.m. pain level of 5. Clinical Record review revealed Resident R29 was admitted to the facility June 17, 2020 with a diagnosis that included chronic respiratory failure, cerebral infarctionv (blood supply to part of the brain is blocked or reduced), and pain. Review of Resident R29's physician's order, dated April 12, 2025, revealed an order for Oxycodone-Acetaminophen 5-325 mg tablet, 2 tablets by mouth every 6 hours as needed for severe pain for pain level of 6-10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of two months of Resident R29's medication administration record revealed Oxycodone-Acetaminophen 5-325 mg tablet, 2 tablets was administered for the following pain levels: -April 28, 2025 at 8:14 a.m. pain level of 4. -April 29, 2025 at 10:26 p.m. pain level of 5. Interview on May 7, 2025 at 2:07 p.m. with Director of Nursing, Employee E2, confirmed the facility staff administered Resident R11's and Resident R29's pain medication outside of the parameters of the physician's orders. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12 (d)(5) Nursing services

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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. Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to ensure that the physician documented the pharmacist identified irregularities were reviewed and failed to document the action taken or not taken to address irregularities for two of five residents reviewed. (Resident R18 and resident R42) Findings: Review of facility policy titled Medication Regime Reviews revised February 2025, revealed a pharmacist performs a medication regime review (MRR) for every resident in the facility receiving medication for the purpose of promote positive outcomes while minimizing adverse consequences and potential risks associated with the medication identified irregularities. The medication regime review (MRR) reports including physician responses are maintained as a part of the permanent medical record. After receiving the MMR report from the pharmacist, the attending physician reviews and responds to the report then documents in the residence medical record that the pharmacist recommendations have been reviewed and if any actions were taken to address them. Review of Resident R18's quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated April 13, 2025, revealed that the resident entered the facility March 6, 2025, and had diagnoses' including diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose), anemia (a condition in which the blood does not have enough red blood cells to carry oxygen through the body), hypotension (high blood pressure), quadriplegia(a condition that causes paralysis in a persons limbs) and seizure disorder (an uncontrolled, abnormal electrical activity in the brain that can cause temporary abnormalities in muscle tone or movements). Continued review revealed that the resident required medications: insulin, antipsychotics, opiods antianxiety. Review of resident's pharmacist recommendations dated January 6, 2025, revealed that the pharmacist reported that Resident R18 wascurrently receiving zinc supplement and stated to please note that over supplementation of zinc has been linked to gastrointestinal irritation, taste disturbance, and possible decrease in healing and instructed to please evaluate the need and consider discontinuing zinc after two weeks. Further review of this pharmacy recommendation revealed that the recommendation document was not signed or dated by a physician. Continued review of pharmacist recommendation revealed that this recommendation to evaluate and discontinues the supplement zinc was resubmitted February 7, 2025 and April 8, 2025, neither was signed or dated by a physician and there was no evidence of evaluation or consideration of the supplement zinc discontinued. Review of Resident R42's quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated February 25, 2025, revealed that the resident entered the facility May 23, 2024, with diagnosis' including seizure disorder (a uncontrolled, abnormal electrical activity in the brain that can cause temporary abnormalities in muscle tone or movements), anxiety, and depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R42's pharmacy recommendations dated April 5, 2025, revealed that Resident 42 was ordered Depakote (medication to treat seizures), and there was no Valproic acid level (Valproic acid has a narrow therapeutic range, meaning the difference between a dose that is effective and one that is potentially toxic is small) in the clinical record. It was suggested for Valproic level to be obtain to monitor therapy. Continued review of this pharmacist recommendation document revealed the physician agreed, signed and dated the document. Review of Resident R42's clinical record revealed that there was no indication that any labs were ordered or completed for resident 42's Valproic level to maintain medication therapy. 28 Pa. Code 211.9(k) Pharmacy services 28 Pa Code 211.12(c) Nursing services