STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395917	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brinton Manor Nursing and Rehabilitation Center	549 Baltimore Pike Glen Mills, PA 19342

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. Based on clinical records review and staff interviews, it was determined that the facility failed to follow physician orders regarding administration of medications for one of the 9 residents reviewed (Resident 1). Findings include: Review of Resident 1's clinical records revealed medical diagnosis that include Cochlear Implant (electronic device to improve hearing), Hypothyroidism (thyroid gland not making enough thyroid hormone), Hyperlipidemia (high level of lipids (fat, oil cholesterol) in the blood), Diabetes Mellitus type 2 high blood sugar), and Legally Blind. Review of Resident 1's clinical records revealed a progress note dated January 18, 2025, at 11:06 p.m. documenting while administering evening medication writer explained resident's medication to orientee and instructed orientee to give medication to resident. Orientee went into room introduced self and called [Resident 10] (another resident's name) and [Residen 1] answered. Orientee informed [Resident 1] that he/she had [Resident 10's] medication and administered medication. Orientee asked door bed (Resident 10) did he/she want his/her medications, the resident replied yes and orientee informed writer of resident's response. Writer realized orientee misheard and gave medications to the wrong resident. Writer informed supervisor, on call doctor was notified and ordered resident to be monitored for 9 shifts. Family was notified. Further review of Resident 1's clinical records revealed the resident had no change in mental or functional status following the incident. Review of facility records revealed a medical error incident report dated January 18, 2025. Review of the incident report notes the Interdisciplinary Team met on January 23, 2025. Disciplinary action given as well as education on the five rights of medication administration. Interview on March 19, 2025, at 12:55 p.m., with the Nursing Home Administrator (NHA) and Director of Nursing (DON) when the above was presented, the DON confirmed that Resident 1 was mistakenly given his/her roommate's medications which included Gabapentin (used to treat nerve pain and seizures), Baclofen (a muscle relaxer), and Vistaril (used to treat itching, anxiety and nausea). The DON confirmed that Resident 1 exhibited no side effects from taking the wrong medications. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(3)(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