STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396009	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norriton Square Nursing and Rehabilitation Center	1700 Pine 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review, review of facility documentation and interviews with staff, it was determined that the facility failed to ensure a resident was free from misappropriation related to missing medication for one of three residents reviewed (Resident R1). Findings include: Review of facility policy, Abuse Prohibition dated October 24, 2022, revealed, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation for all residents. Continued review revealed, Misappropriation of patient property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent. Review of Resident R1's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated June 4, 2025, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including cancer and chronic pain. Continued review revealed that the resident frequently has pain that interferes with sleeping and day-to-day activities. Review of Resident R1's care plan, dated initiated November 11, 2019, revealed that the resident is at risk for alterations in comfort related to chronic pain with interventions including encouraging the resident to request pain medication before pain becomes severe and to medicate the resident as ordered. Review of Resident R1's physician orders revealed an order, dated August 29, 2025, for oxycodone (opioid pain medication) 5 m.g (milligrams) give one tablet two times a day for chronic pain. Review of facility documentation submitted to the Pennsylvania Department of Health on September 2, 2025, revealed that on September 1, 2025, Employee E7, licensed nurse, discovered that 30 tablets of oxycodone for Resident R1 were unaccounted for in the narcotic drawer. The facility identified Employee E8, agency licensed nurse, as the alleged perpetrator. Review of Controlled Substance Inventory Count Sheets revealed that Employee E7, licensed nurse, worked on the 3A medication cart on August 29, 2025, from 3:00 p.m. through August 30, 2025, at 7:00 a.m. During the 11:00 p.m. to 7:00 a.m. shift, Employee E7, licensed nurse, documented that she received a container of oxycodone 5 m.g tablets and a Controlled Drug Record sheet for Resident R1. Review of the Pharmacy Shipping Manifest revealed that 30 tablets of oxycodone 5 m. g tablets for Resident R1 were delivered to the facility on August 29, 2025. Continued review of Controlled Substance Inventory Count Sheets revealed that Employee E7, licensed nurse, worked on the 3A medication cart again on August 30, 2025, from 3:00 p.m. through August 31, 2025, at 7:00 a.m. Employee E7, licensed nurse, signed the Controlled Substance Inventory Count Sheet at the end of her shift documenting that there were 14 containers of medications in the narcotic drawer and 13 corresponding controlled drug record sheets. Employee E8, agency licensed nurse, signed the Controlled Substance Inventory Sheet that she was the oncoming nurse on August 31, 2025, at 7:00 a.m. and documented that there were 13 containers of medications in the narcotic drawer and 13 controlled drug record sheets. Further review of Controlled Substance Inventory Count Sheets revealed that Employee E7, licensed nurse, worked on the 3A medication cart again on August 31, 2025, as the oncoming nurse at 11:00 p.m. and documented that there were 13 containers of medications in the narcotic drawer and 12 controlled drug record sheets. There was no signature or count from Employee E8, agency licensed nurse, when she left the shift at 11:00 p.m. Interview on September 4, 2025, at 1:58 p.m. Employee E7, licensed nurse, stated that she worked Saturday, August 30, 2025, from 3:00 p.m. through 7:00 a.m. the next morning. Employee E7, licensed nurse, stated that Employee E8, agency licensed nurse, relieved her on Sunday morning and that Employee E8 worked on August 31, 2025, from 7:00 a.m. through 11:00 p.m. Employee E7, licensed nurse, stated that she relieved Employee E8, agency licensed nurse, on Sunday night August 31, 2025, at 11:00 p.m. Employee E7, licensed nurse, continued that while counting Sunday night during shift change, Employee E8, agency licensed nurse, was in a rush and that after counting narcotic medications they went straight into report (process of informing oncoming staff of resident status). Employee E7, licensed nurse, stated that she does not remember what time during her shift when she signed the Controlled Substance Inventory Count Sheet and confirmed that Employee E8, agency licensed nurse, did not sign the sheet at the end of her shift. Employee E7, licensed nurse, stated that she performs a narcotic count for herself prior to the end of her shift in preparation for shift change and that's when she realized that the count was not correct. Employee E7, licensed nurse, stated she remembered that Resident R1 had received a card (30 tablets) of oxycodone a few day prior and that the medications and corresponding controlled drug record sheet were missing. Employee E7, licensed nurse, immediately reported this to the supervisor. An interview with Employee E8

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for two of three residents reviewed (Residents R1 and R2). Findings include: Review of facility policy, Management of Controlled Drugs dated January 31, 2025, reveled, A complete count of all Schedule II-IV controlled substances is required at the change of shifts per state regulation or at any time in which the narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses. Review of Resident R1's physician orders revealed an order, dated August 29, 2025, for oxycodone (opioid pain medication) 5 m.g (milligrams) give one tablet two times a day for chronic pain. Review of Controlled Substance Inventory Count Sheets revealed that Employee E7, licensed nurse, worked on the 3A medication cart on August 29, 2025, from 3:00 p.m. through August 30, 2025, at 7:00 a.m. During the 11:00 p.m. to 7:00 a.m. shift, Employee E7, licensed nurse, documented that she received a container of oxycodone 5 m.g tablets and a Controlled Drug Record sheet for Resident R1. Review of the Pharmacy Shipping Manifest revealed that 30 tablets of oxycodone 5 m.g tablets for Resident R1 were delivered to the facility on August 29, 2025. Continued review of Controlled Substance Inventory Count Sheets revealed that Employee E7, licensed nurse, worked on the 3A medication cart again on August 30, 2025, from 3:00 p.m. through August 31, 2025, at 7:00 a.m. Employee E7, licensed nurse, signed the Controlled Substance Inventory Count Sheet at the end of her shift documenting that there were 14 containers of medications in the narcotic drawer and 13 corresponding controlled drug record sheets. Employee E8, agency licensed nurse, signed the Controlled Substance Inventory Sheet that she was the oncoming nurse on August 31, 2025, at 7:00 a.m. and documented that there were 13 containers of medications in the narcotic drawer and 13 controlled drug record sheets. Further review of Controlled Substance Inventory Count Sheets revealed that Employee E7, licensed nurse, worked on the 3A medication cart again on August 31, 2025, as the oncoming nurse at 11:00 p.m. and documented that there were 13 containers of medications in the narcotic drawer and 12 controlled drug record sheets. There was no signature or count from Employee E8, agency licensed nurse, when she left the shift at 11:00 p.m. Interview on September 4, 2025, at 1:58 p.m. Employee E7, licensed nurse, was unable to explain to discrepancy on the Controlled Substance Inventory Count Sheets for Resident R1. Continued review of Resident R1's physician orders revealed an order, dated May 23, 2025, for oxycodone 5 m.g give one tablet every 12 hours as needed for pain. Review of Resident R1's Controlled Drug Record sheets for oxycodone 5 m.g tablets revealed that the resident was administered a dose on August 11, 2025, at 6:00 p.m. Review of Resident R1's Medication Administration Records for August 2025, revealed no indication that the resident was administered the medication at that time. Continued review of Resident R1's Medication Administration Records revealed that the resident was administered oxycodone 5 m.g on August 29 and 30, 2025, at 9:00 p. m. Review of Resident R1's Controlled Drug Record sheets for oxycodone 5 m.g tablets revealed no indication that the resident was administered the medication at those times. Review of physician's orders for Resident R2 revealed orders, dated July 8, 2025, and August 22, 2025, for oxycodone 10 m.g tablets give one tablet every eight hours as needed for pain. Review of Resident R2's Controlled Drug Record sheets for oxycodone 10 m.g revealed that the resident was administered the following doses:August 5, 2025, at 12:00 a.m.;August 11, 2025, at 10:00 a.m.;August 15, 2025, at 2:00 a.m.;August 20, 2025, at 9:00 p.m.;August 21, 2025, at 2:20 a.m.;August 23, 2025, at 7:00 p.m.;August 28, 2025, at 9:00 a.m.; andAugust 30, 2025, at 1:00 p.m Review of Resident R2's Medication Administration Records for August 2025, revealed no indication that the resident was administered the medication at those times. Interview on September 4, 2025, at 2:48 p.m. the Director of Nursing was unable to explain the discrepancies on Resident R1 and R2's Controlled Drug Record sheets and Medication Administration Records. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.9(k) Pharmacy services

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility policies, review of facility documentation, review of personnel files and interviews with staff, it was determined that the facility failed to ensure that nursing staff received training on abuse, neglect, exploitation and misappropriation of resident property as required for two of three nursing staff reviewed (Employees E4 and E8). Findings include: Review of facility policy, Abuse Prohibition dated October 24, 2022, revealed, Training and reporting obligations will be provided to all employees through orientation, code of conduct training and a minimum of annually. Interview on September 4, 2025, at 10:19 a. m. Employee E4, agency licensed nurse, stated that it was her first day working at the facility. Employee E4, agency licensed nurse, stated that when she arrived for her shift, she was given report from the night nurse and showed around the nursing unit. Employee E4, agency licensed nurse, stated that she completed some online training prior to working at the facility but was unable to specify what topics were reviewed. Review of facility documentation submitted to the Pennsylvania Department of Health on September 2, 2025, revealed that on September 1, 2025, Employee E7, licensed nurse, discovered that 30 tablets of oxycodone (opioid pain medication) for Resident R1 were unaccounted for in the narcotic drawer. The facility identified Employee E8, agency licensed nurse, as the alleged perpetrator. An interview with Employee E8, agency licensed nurse, was requested, however, the employee has not responded to any requests. Abuse training records for Employees E4 and E8, agency licensed nurses, were requested, but were not provided at any time during the survey. Interview on September 4, 2025, at 2:48 p.m. the Director of Nursing revealed that agency staff are expected to complete required trainings through their agencies. The Director of Nursing was unable to retrieve training records specific to abuse, neglect, exploitation and misappropriation of resident property for Employees E4 and E8, agency licensed nurses, and stated that she was still waiting for the staffing agency to provide the training records. The Director of Nursing was unable to verify if Employees E4 and E8, agency licensed nurses, had completed any training specific to abuse, neglect, exploitation and misappropriation of resident property. 28 Pa Code 201.19(7) Personnel policies and procedures 28 Pa Code 201.20(a)(b) Staff development