STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396017	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehabilitation Will	3485 Davisville Road Hatboro, PA 19040

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record review, interviews with staff, reviews of the pharmacy delivery schedule, hospital record and policy and procedure reviews, it was determined that the facility failed to acquire and dispense medications as ordered by the physician for one of three residents reviewed. (Resident R1) Findings include: A review of the policies titled Pharmacy Services dated Janaury 1, 2022 it was detailed that the licensed nurse receives orders for medications and treatments from the physician. The licensed nurse was responsible for verifying the orders for medications and treatments with the physician. The licensed nurse was responsible for reconciling orders for medications and treatments with the physician upon admission of the resident to the facility. Upon admission/readmission to the facility the licensed nurse was to communicate by sending the electronic prescriptions for medication and treatments to the pharmacy services. The policy also indicated that some complex orders such as titration orders, infusion therapy orders, wound care orders or alternating dosing orders would require licensed nursing staff to print or fax the orders to the pharmacy. This policy indicated that upon receipt of medications from the pharmacy, that have been electronically prescribed by the attending physician, the licensed nursing staff were expected to reconcile the medications received to the orders entered in the resident's clinical record. The licensed nursing staff were then responsible for notifying the physician prescribing the medications or treatments of any discrepancies with the electronically prescribed orders, medications and treatments received from the pharmacy services. A review of the pharmacy delivery schedule revealed that when the nursing staff communicated a medication or treatment order to the pharmacy by 9:00 p.m., Monday through Friday that the medication and treatment was scheduled for delivery at 12:30 a.m., the following morning. A review of the pharmacy delivery schedule for Saturdays and Sundays revealed that when the nursing staff communicated the medication or treatment order to the pharmacy by 4:00 p.m., that the pharmacy was scheduled to deliver the medication by 5:30 pm the same day. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident R1 revealed that this resident was admitted to the facility at 7:00 p.m., on February 20, 2024. According to the nursing admission assessment on February 20, 2024, Resident R1 was having pain in the left foot wound site after a transmetatarsal amputation (a surgical procedure involving removal of a portion of the foot). The physician's progress note dated February 21, 2024 indicated that Resident R1 was admitted for antibiotic therapy following consultation with an infectious disease specialist at the hospital. The physican indicated in this progress note that Resident R1 had a history of osteomyelitis (a bone infection caused by bacteria or fungi;the bone infection causes bone pain and recurring drainage) of the left foot. Clinical record documentation indicated that the physician ordered antibiotic medication for Resident R1 upon admission to the facility. The physician ordered Linezolid (antibiotic) 600 milligrams (mg) twice a day for osteomyelitis until March 8, 2024. The physician also ordered Meropenem (antibiotic) IV 200 mg three times a day for osteomyelitis until March 8, 2024. A review of the hospital record dated February 22 through February 24, 204 for Resident R1 revealed that this resident returned to the hospital on February 22, 2024. The hospital record indicated that Resident R1 returned to the hospital because the nursing home did not have the antibiotics that were ordered by the physician to be administered to Resident R1, upon admission to the facility on [DATE]. A review of the medication administration record for Resident R1 for the months of February, 2024 confirmed that six doses of Linezolid medication as ordered by the physician were omitted for Resident R1 on February 21, 2024 at 9:00 a.m., February 21, 2024 at 9:00 p.m., February 22, 2024 at 9:00 a.m., February 24, 2024 at 9:00 p.m., February 25, 2024 9:00 a.m., February 28, 2024 at 9:00 a.m., February 29, 2024 at 9:00 a.m. A review of the medication administration record for Resident R1 for the months of February, 2024 confirmed that six doses of Meropenem medication as ordered were omitted for Resident R1 on February 21, 2024 at 9:00 a.m., on February 21, 2024 at 5:00 p.m., on February 21, 2024 at 9:00 p.m., on February 22, 2024 at 9:00 a.m., on February 24 at 5:00 p.m., on February 24, 2024 at 9:00 p.m. Interview with the Director of Nursing, Employee E2, at 10:00 a.m., on March 6, 2024 confirmed that medications (antibiotics) were not administered according with physician's orders for Resident R1. Interview with the Licensed nursing staff, Employees E4, E5, E6 and E7 at 11:30 a.m., on March 6, 2024 revealed that the pharmacy service was not delivering medications to the facility regularly. The employees confirmed that the medications are frequently not available for administration to the resident, as ordered by their physician. The nursing staff said that due to the untimely delivery of medications to the facility the residents were missing doses of the medications. Interview with the Nursing Home Administrator, Employee E1 at 1:00 p.m., on March 6, 2024 confirmed the identified lack of timely delivery and professional services from the outside pharmacy group that was assigned to the facility. The administrator confirmed the lack of availability of antibiotic medications as ordered by the physican for administration to Resident R1 from February 20 through March 1, 2024 during the resident's stay at the facility. 28 Pa. Code 211.9(a)(1)(b)(c)(d)(4) Pharmacy services (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 201.18(b)(1)(3)(e)(1)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services