STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396144	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exton Post Acute	501 Thomas Jones Way Exton, PA 19341

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on review of clinical records, incident reports, policy review, and staff interviews it was determined the facility failed to ensure that one of 18 residents reviewed was free of a significant medication error, which compromised the resident's clinical condition and resulted in actual harm when the resident required a hospital admission. This is being cited as past noncompliance. (Resident R1) Findings Include: Review of facility policy titled, Reconciliation of Medications on Admission undated, revealed, the purpose of the procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Review of facility policy titled Administering Medications undated, revealed the purpose of the policy is to ensure medications are administered in a safe and timely manner, and as prescribed. Review of Resident R1's Face Sheet revealed an admitted [DATE], with medical diagnoses including fracture of the right femur (break of the thigh bone), Type 2 Diabetes Mellitus (insulin resistance and elevated blood sugar levels), Cerebral Infraction (aka: stroke), Peripheral Vascular Disease (disorder of blood vessels outside the heart), and Anemia (red blood cell deficiency). Review of Resident R1's clinical records revealed a hospital discharge summary, dated March 25, 2025, documenting a list of Resident R1's discharge medications which included Amlodipine 10mg (medication taken for blood pressure), Apixaban 5mg (milligram) (aka: Eliquis- blood thinner), Atorvastatin 80mg (cholesterol), Losartan 100mg (blood pressure, stroke, and diabetes), Loratadine 10mg (medication used to treat allergies), Metformin XR 500mg (diabetes), Trazodone 150mg (antidepressant), and Vascepa 1gr (gram) (medication used to reduce heart attack and stroke). Review of Resident R1's clinical record failed to reveal a physician's order for Apixaban 5mg. Further review of Resident R1's clinical record failed to reveal on Medication Administration Record an order for Apixaban from March 25, 2025 through April 3, 2025. (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's clinical records revealed physician progress note dated April 3, 2025, documenting the resident was seen due to a cold, left foot with no palpable (felt) pulse per nursing, has history of Peripheral Artery Disease, Superficial Femoral Artery disease (SFA) stenting (small wire used to increase blood or fluid flow). Resident on Eliquis but no antiplatelet (blood clot reducer) agent. Recommendation made for stat (immediate) arterial doppler. Further review of Resident R1's clinical records revealed an encounter progress note dated April 4, 2025 (1:00 a.m.) indicating Resident R1's previously ordered doppler of left lower extremity unable to be performed due to unavailable technician, transfer to hospital for further evaluation. Review of Resident R1's clinical records revealed a progress note dated April 4, 2025, at 4:40 a.m., documenting Resident R1 was admitted to the hospital for treatment of Popliteal Artery Embolism (critical vascular condition characterized by the obstruction of blood flow in the right popliteal artery, located behind the kneee, due to an embolus/blood clot which increases risk of limb loss). Review of Resident R1's clinical record including hospital discharge summary revealed Resident R1 was admitted to the hospital on April 4, 2025, with history of Coronary Artery Disease, Peripheral Artery Disease, Atrial Fibrillation, Diabetes Mellitus Type 2, who presented with cold extremity. Resident R1 was found to have a Popliteal Thrombus (blood clot in vein behind knee) and underwent a Thrombectomy (surgical procedure to remove the blood clot). Resident R1 was transitioned from Plavix (medication used to prevents platelets from forming blood clots. Used for preventing heart attacks and strokes in high-risk patients) and Aspirin to Eliquis (medication blocks a protein that helps form blood clots. Used for atrial fibrillation (irregular heartbeat) to prevent stroke) and Aspirin alone. Review of Resident R1's clinical records revealed a progress note dated April 8, 2025, at 5:58 p.m., documenting the resident was readmitted to the facility. Review of Resident R1's clinical records revealed a hospital discharge summary, dated April 8, 2025 indicating Resident R1's discharge medications including Amlodipine 10mg (medication used to manage high blood pressure), Apixaban 5mg (blood thinner), Atorvastatin 80 mg (medication used to treat cholesterol), Losartan 100mg (blood pressure, stroke, and diabetes), Loratadine 10mg (allergies), Metformin XR 500mg (medication used to control high blood sugar levels), Trazodone 150mg (antidepressant medication), Vascepa 1gr (medication to reduce risk of heart attack and stroke). Venlafaxine XR 150mg (antidepressant medication), and Oxycodone 5mg (medication used to alleviate moderate to severe pain). Review of Resident R1's clinical records revealed a progress note dated April 9, 2025, at 12:16 p.m., documenting Eliquis (Apixaban) ordered and started. Review of Resident R1's clinical records revealed a care plan initiated on April 9, 2025, documenting the resident is on anticoagulant therapy related to Atrial Fibrillation (irregular heart rhythm). (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of information dated April 9, 2025, submitted by the facility to Department of Health revealed during Resident R1's readmission review on April 9, 2025, the team identified a potential transcription error for the medication Apixaban, an anticoagulant. QAPI (Quality Assurance Performance Improvement) was initiated and concluded a transcription error occurred and Apixaban was omitted during the resident's original admission of March 25, 2025, subsequently the resident missed 10 days of this medication from March 25, 2025, through April 3, 2025. The resident was sent to the emergency room and admitted to the hospital on April 4, 2025, with a diagnosis of Popliteal Artery Embolism. Further review of the information dated April 9, 2025, submitted by the facility to the Department of Health revealed on April 11, 2025, after Director of Nursing's completed investigation, chart audits were performed for all new admissions for past 14 days to ensure accuracy of transcribed orders and compared to the hospital discharge instructions. Education was provided to professional staff to review the admission process and double check accuracy to mitigate medication errors. Review of facility records revealed witness statement dated April 11, 2025, documenting Registered Nurse, Employee E4 entered orders for the resident, she did not enter the Apixaban due to having concerns about the order. The physician's order indicated Resume 9/18/24. Employee E4 left the order to be followed up with the nurse on duty, LPN Employee E5. Employee E5 did not follow up on the order. Interview of Registered Nurse, Employee E4, on April 15, 2025, at 2:30 p.m., stated he/she was assisting Licensed Practical Nurse (LPN) Employee E5 with admissions as there were four admissions during the shift and only one nurse. Employee E4 stated there was a note on the resident's hospital discharge medication list concerning the resident's Apixaban which indicated, Apixaban 5 mg oral 2 times daily, resume 9/18/2024. Employee E4 stated he/she notified Employee E5 and informed E5 to ask about this. Per Employee E4, Employee E5 failed to follow up therefore the resident's medication was not entered into the system. Interview conducted with Nursing Home Administrator (NHA), Director of Nursing (DON), and [NAME] President of Operations (VPO) on April 15, 2025, at 2:00 p.m. when the above information was presented. The Nursing Home Administrator, Director of Nursing and [NAME] President of Operations confirmed the incident occurred, indicating that a plan of correction had already been put into place, and provided evidence of the plan of correction. Per the NHA Employee E5 was on vacation from April 9, 2025, through April 23, 2025, and was unavailable for interview. Review of facility educational documents revealed a 24-Hour Chart Check Process in-service training sheet dated April 13, 2025, containing nine nursing staff signatures. Review of facility records revealed a Medication Reconciliation Process training inservice sign in sheets dated April 14, 2025, documenting 17 nursing staff signatures and for April 15, 2025, containing 20 nursing staff, of which six are PRN (as needed), were educated via telephone and required to sign the in-service attendance sheet prior to starting their next shift. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of facility documentation revealed a Message Blast (text message sent to staff) dated April 14, 2025, indicating for all nursing staff to note admit nurse signs on the after-visit summary (AVS- utilized for new admissions), medications reviewed with physician, note in PCC (Point Click Care- electronic medical record) 2nd nurse reviews medications AVS (after visit summary) and signs ok (to confirm order). Any unclear (questionable) orders need verified by physician as soon as possible, enter order on-hold until clarified. You need to sign education in supervisor book next time you work, please verify receipt. Review of facility records revealed a Medication Reconciliation Policy with in-services sign in sheets documenting the staff was retrained on the medication reconciliation policy. The purpose of the policy was to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Further review revealed a policy titled Administering Medications with in-service sign in sheets documenting the staff was retrained on the administering medications policy. The purpose of the policy was to ensure medications are administered in a safe, timely manner and as prescribed. Interviews conducted on April 15, 2025, approximatley 1:00 p.m and 2:00 p.m., with Employee E4, Employee E6, Employee E7, Employee E8, and Employee E9, confirmed education topics and knowledge of medication protocols as well as training for Medication Reconciliation on April 14, 2025. Review of audits conducted by the facility revealed newly admitted residents had medications verified and AVS was signed by two nurses, with no discrepancies noted. The facility failed to administer medication as ordered due to a transcription error upon initial admission for Resident R1 causing actual harm when Resident R1 was hospital for a Popliteal Artery Embolism. The deficiency is past non compliance. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(e)(1) Management 28 Pa Code 211.12(c)(d)(3) Nursing services