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	12/15/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of hospital and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician's order from the hospital was followed and accurately communicated to the facility's physician for one of the two residents reviewed (Resident CL1). Findings include:Clinical records review revealed Resident CL1 was admitted to the facility on [DATE] at aproximately 5:00 p.m., with the following diagnoses of falls and Atrial fibrillation (Irregular heartbeat).A review of Resident CL1's hospital record After Visit Summary dated October 16, 2025, revealed Resident CL1 was ordered and administered Warfarin (A medication that thins the blood) four milligrams (mg) in the hospital on October 16, 2025. Additional hospital records revealed that the resident had orders for Warfarin 3 milligrams and Warfarin 6 milligrams (total of 9 milligrams) on March 30, 2022. Further review revealed the resident's INR level (International Normalized Ratio- A standard blood test that measures how long it takes for your blood to clot) dated October 17, 2025, at 7:31 a.m., revealed an 8.8 result (high-a therapeutic level for a resident on moderate intensity anticoagulation should be between 2.0-3.0). The same report revealed as follows: Instructions: Please hold the Coumadin dose throughout the weekend. You need to see [name of the physician] on Monday to have your INR / Coumadin level rechecked. Please call today to make that appointment, or maybe the staff at [name of the skilled facility where the resident was admitted] can have their medical staff doctor order the repeat blood test on Monday (October 20, 2025).A review of Resident CL1's October 2025 Medication Administration Record revealed that on Friday October 17, 2025, at 9:00 p.m., the resident was ordered and administered Warfarin 3 mg and Warfarin 6 mg, for a total dose of 9 mg.A review of the nursing progress notes dated October 17, 2025, at 11:09 p.m., revealed Resident CL1 was sent to the emergency room via 911 due to impulsive behavior, anxiety, and getting out of bed into the floor mats. Physicians and family were notified.A review of the nursing progress notes dated October 18, 2025, at 1:21 p.m., revealed that the resident's family called and informed the facility that Resident CL1 was admitted for an elevated PT/INR result.A review of the hospital records dated October 18, 2025, at 3:24 a.m., revealed Resident CL1 had an INR level of 11.2. Admitting diagnoses were multiple falls with possible fracture of the left 5th, 6th, and 7th ribs, hematoma of left lower extremity, and an elevated INR.An interview with the Director of Nursing (DON) was conducted on December 15, 2025, at 12:00 noon. The DON reported that the admitting nurse verifies orders from the hospital to the resident's physician/NP (nurse practitioner), then enters the order to the resident's electronic medical records.An interview was conducted with the NP on December 15, 2025, at 12:05 p.m. The NP confirmed they were not notified of the hospital's instruction to hold the residents' Warfarin for the weekend and ordered 9 milligrams (which was an old order from March 2022 and not 4 mg of coumadin which was the last amount prescribed on October 16, 2025 while in the hospital) of coumadin to be given the night of October 17, 2025.The above was conveyed with the DON and Nursing Home Administrator on December 15, 2025, at 1:30 p.m.The facility failed to ensure the physician's order for Warfarin medication from the hospital was followed and accurately communicated with the facility's physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa Code 211.5(f) Clinical Records