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	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehabilitation Exto	501 Thomas Jones Way Exton, PA 19341

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on clinical records review and staff interview, it was determined that the facility failed to notify the physician of a significant weight change for one of the 22 residents reviewed (Resident 39). Findings include: Review of Resident 39's clinical records revealed resident was admitted to the facility on [DATE], after brain surgery for a tumor resection. Further review of Resident 39's clinical record revealed additional diagnoses of Diabetes (group of metabolic disorders characterized by a high blood sugar level over a prolonged period), and Chronic Kidney Disease (CKD). Review of Resident 39's weights and vitals revealed an admission weight of 297. 1 pound on February 16, 2024. The resident was again weighed on February 17, 2024, with the result of 296.9 lbs. Review of Resident 39's weights and vitals dated February 21, 2024, revealed a weight of 353.2 lbs. A re-weight conducted on February 22, 2024, revealed a weight of 362 lbs., a 65.1-pound (17.98%) weight gain in five days. Review of dietitian's progress notes dated February 22, 2024, revealed that the significant weight change was identified and is likely related to scale variance. The note revealed that the admission weight was taken from the hospital record and no new interventions were warranted at this time. Review of Resident 39's clinical record failed to reveal the physician was notified of Resident 39's significant weight gain identified on February 22, 2024. Review of the physician's progress notes dated March 5, 2024, revealed Resident 39 reported a concern about his/her weight change/discrepancy. Interview with the Dietitian, Employee E5, was conducted on March 16, 2024, at 11:00 a.m. Employee E5 confirmed that Resident 39's baseline weight was from the hospital record. Employee E5 confirmed that the physician was not notified of the significant weight change until mentioned by the resident as documented on March 5, 2024. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Employee E3 conducted on March 16, 2024, at 1:00 p.m., confirmed Resident 39's significant weight change was not reported timely to the physician. The facility failed to ensure physician was notified of the significant weight change of Resident 39. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on review of the facility's policy, clinical records, and staff interview, it was determined that the facility failed to ensure a baseline care plan was developed for one of the 22 residents reviewed (Resident 67). Findings include: Review of the facility's policy titled Person-Centered Care Plan, dated October 24, 2022, revealed the facility must develop and implement a baseline person-centered care plan within 48 hours of admission, readmission for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. Review of Resident 67' clinical record revealed Resident 67 was readmitted to the facility on [DATE], with a diagnosis of Osteomyelitis (bone infection) to the sacrum (tail bone). Review of Resident 67's physician's order sheet dated January 26, 2024, revealed an order for Piperacillin Sod-Tazobactam (Antibiotic) Intravenous Solution 3.375 gm intravenously every six hours for wound infection. Review of Resident 67 ' s care plan failed to reveal that a baseline care plan was developed for residents receiving IV (intravenous - medication administered in the vein) antibiotics for wound infection. Interview with Employee E3 conducted on March 15, 2024, at 1:00 p.m. confirmed Resident 67's care plan for IV antibiotics for wound infection was not developed. The facility failed to ensure Resident 67's baseline care plan for IV antibiotics was developed. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa Code: 211.10(c) Resident care policies

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37789 Based on review of facility policy, clinical record, and facility documentation, it was determined that the facility failed to timely assess, monitor, and treat for suspected laundry detergent poisoning of Resident 222, resulting in actual harm of vomiting and diarrhea with a subsequent hospitalization to the Intensive Care Unit (ICU) for one of 22 residents reviewed. Findings include: Review of facility policy, Poisoning, effective December 1, 2006, revealed: Upon discovery of suspected poisoning, call for help and instruct staff to call 911. Review of Resident 222's clinical record revealed a diagnosis of Dementia (loss of cognitive functioning that interferes with daily life and activities) with behavioral disturbances. Review of Resident 222's July 2023 Admission MDS (Minimum Data Set - periodic assessment of resident care needs) revealed a BIMS (Brief Interview of Mental Status) was unable to be completed due to the resident's cognitive impairment. Review of Resident 222's nursing progress notes revealed a nursing note from Licensed Nurse Employee 12 dated November 17, 2023, at 1:44 a.m., indicating: Previous nurse [(Licensed Nurse Employee 11)] reported that resident was found with laundry pods around 1530 [(3:30 p.m.)] opened in his room. Nurse reported he seemed fine. About 2030 [(8:30 p.m.)] an aide needed assistance with incontinent care for resident. When I entered the room, resident was sitting on [the bed] with vomit and feces noted around him. Resident was alert. Resident was given a shower assessed and vitals were taken. Resident was able to follow commands during assessment. On call was contacted and spoke with [provider] who gave order to send resident out. Contacted [hospital] who reported patient is currently admitted to ICU with vomiting from ingesting toxic chemical (Gain laundry pods). Daughter was contacted and notified. Review of facility documentation revealed a witness statement from nurse aide Employee 13 dated November 17, 2023, indicating: I was rounding went into [Resident 222's] room at 1530 found [laundry detergent] pods on bedside cabinet ripped open. I suspected that the patient ripped the bag open. I found 1-2 open on the floor. [Licensed Nurse Employee 11] brought [Resident 222] out to nurses station. He seemed ok. Around dinner time he started having loose stools. I went to get towels to clean it up. [Licensed Nurse Employee 11] was at nurses station. She kept sitting there even though she knew [Resident 222] was having loose stools. I had to get [another nurse aide] to help me. We cleaned him up and put him in bed. At 7:30 he sat up - he had vomited. I got [Licensed Nurse Employee 12] & I showered him again. I asked [Licensed Nurse Employee 12] if we need to call poison control. She said she was calling [provider.] [Emergency Medical Services] arrived about 9pm. Further review of nurse aide Employee 13's witness statement revealed: I reported the findings of the ripped open bag of pods to nurse @1550. I reported the diarrhea at dinner time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of facility documentation revealed a witness statement from Licensed Nurse Employee 11, undated, which revealed: Nurse made aware by [nurse aide] at 6pm that patient had an opened bag of laundry pads [pods] in his room. Patient was found sitting in the chair in his room. [Vital signs stable.] No signs of distress or pain noted. Visualized [his] mouth and mucous membranes pink and moist. No abnormal smell noted. No residue around mouth or on his hands was noted. Inspected room, no signs that pods was used or tampered with. Patient brung out to the nurses station. Patient sat and flipped through a book. Snack was given. Consumed 100%. Report given to oncoming nurse. Review of Resident 222's clinical record failed to reveal documented evidence that the resident was assessed or vital signs were obtained following Nurse Aide Employee 13's witnessed account from 3:30 p.m. on November 16, 2023. Review of Resident 222's clinical record failed to reveal documented evidence the physician was notified at the time Resident 222's was found with an open laundry detergent pod. Review of Resident 222's clinical record and facility documentation revealed resident was unable to articulate if he/she ingested the contents of the laundry detergent pod due to impaired cognition and poor safety awareness. Review of Resident 222's clinical record and facility documentation failed to reveal evidence of staff contacting Poison Control or researching signs/symptoms of laundry detergent poisoning at the time Resident 222 was observed with open laundry deteregent pod and possible ingestion of the contents. Review of Resident 222's emergency room notes revealed: Reported to be found by staff at 1500 today with an open bag of laundry detergent pods next to him [Patient] reported to be vomiting and having diarrhea-unknown time of onset EMS dispatched at 2113 for a poisoning- arrived at 2123 to find [patient] 78% on Room air [(normal is 95-100%] , sitting up in a recliner slumped over. [Patient] arrives on nebulizer, slumped forward, emesis [(vomit)] bag with bright orange emesis with odor of detergent. Review of Resident 222's discharge summary from the hospital on November 29, 2023, revealed the resident was admitted to the ICU on high flow nasal cannula oxygen, placed on IV fluids and IV antibiotics, had a chest x-ray that showed aspiration (when fluids or stomach contents are breathed into the lungs), placed on bronchodilators (medications that relax the muscles around your airways and help clear mucus from your lungs) every 4 hours, and required frequent suctioning. Interview with the Interim Nursing Home Administrator and Corporate Nurse on March 15, 2024, at 9:35 a.m. confirmed the (nursing agency) staff failed to timely assess, monitor, and treat Resident 222 for suspected laundry detergent poisoning. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa Code 211.5(f) Clinical Records 28 PA Code 211.10(a) Resident care policies

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38419 Based on review of facility policy, clinical record, and facility documentation, it was determined that the facility failed to ensure a cognitively impaired resident's (Resident 222) environment was free from known environmental hazards including laundry detergent pods resulting in actual harm of suspected poisoning and subsequent hospitalization to the Intensive Care Unit (ICU) for one of 22 residents reviewed. Findings include: Review of facility policy, Poisoning, effective December 1, 2006, revealed: Upon discovery of suspected poisoning, call for help and instruct staff to call 911. Review of Resident 222's clinical record revealed a diagnosis of Dementia (loss of cognitive functioning that interferes with daily life and activities) with behavioral disturbances. Review of Resident 222's July 2023 Admission MDS (Minimum Data Set - periodic assessment of resident care needs) revealed a BIMS (Brief Interview of Mental Status) was unable to be completed due to the resident's cognitive impairment. Review of Resident 222's clinical record revealed a nursing progress note dated November 13, 2023 (15:49 aka 3:49 p.m) indicating pt [patient] AAOx1 [Awake/Alert/Oriented x1] w/ hx [with history] of adv [advanced] dementia. steady gait, able to ambulate independently. impulsive, often wanders and tries to enter other patients' rooms. no s/s [signs/symptoms] of respiratory distress or sob [shortness of breath]. no c/o [complaints of] pain or discomfort. [resident] accepted [his/her] medications crushed with applesauce this morning. pt often refuses care. pt is grossly incontinent and often refuses incontinence care. becomes combative and agitated w/ at times. [Resident] is unable to make [resident] needs known. needs anticipated. call bell within reach. Review of Resident 222's nursing progress notes revealed a nursing note from Licensed Nurse Employee E12 dated November 17, 2023, at 1:44 a.m., indicating: Previous nurse [(Licensed Nurse Employee 11)] reported that resident was found with laundry pods around 1530 [(3:30 p.m.)] opened in his room. Nurse reported he seemed fine. About 2030 [(8:30 p.m.)] an aide needed assistance with incontinent care for resident. When I entered the room, resident was sitting on [the bed] with vomit and feces noted around him. Resident was alert. Resident was given a shower assessed and vitals were taken. Resident was able to follow commands during assessment. On call was contacted and spoke with [provider] who gave order to send resident out. Contacted [hospital] who reported patient is currently admitted to ICU with vomiting from ingesting toxic chemical (Gain laundry pods). Daughter was contacted and notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of facility documentation revealed a witness statement from nurse aide Employee 13 dated November 17, 2023, indicating: I was rounding went into [Resident 222's] room at 1530 found [laundry detergent] pods on bedside cabinet ripped open. I suspected that the patient ripped the bag open. I found 1-2 open on the floor. [Licensed Nurse Employee 11] brought [Resident 222] out to nurses station. He seemed ok. Around dinner time he started having loose stools. I went to get towels to clean it up. [Licensed Nurse Employee 11] was at nurses station. She kept sitting there even though she knew [Resident 222] was having loose stools. I had to get [another nurse aide] to help me. We cleaned him up and put him in bed. At 7:30 he sat up - he had vomited. I got [Licensed Nurse Employee 12] & I showered him again. I asked [Licensed Nurse Employee 12] if we need to call poison control. She said she was calling [provider.] [Emergency Medical Services] arrived about 9pm. Further review of nurse aide Employee 13's witness statement revealed: I reported the findings of the ripped open bag of pods to nurse @1550. I reported the diarrhea at dinner time. Further review of facility documentation revealed a witness statement from Licensed Nurse Employee 11, undated, which revealed: Nurse made aware by [nurse aide] at 6pm that patient had an opened bag of laundry pads [pods] in his room. Patient was found sitting in the chair in his room. [Vital signs stable.] No signs of distress or pain noted. Visualized [his] mouth and mucous membranes pink and moist. No abnormal smell noted. No residue around mouth or on his hands was noted. Inspected room, no signs that pods was used or tampered with. Patient brung out to the nurses station. Patient sat and flipped through a book. Snack was given. Consumed 100%. Report given to oncoming nurse. Review of Resident 222's clinical record failed to reveal documented evidence that the resident was assessed or vital signs were obtained following Nurse Aide Employee 13's witnessed account from 3:30 p.m. on November 16, 2023. Review of Resident 222's clinical record failed to reveal documented evidence the physician was notified at the time Resident 222 was found with an open laundry detergent pod. Review of Resident 222's clinical record and facility documentation failed to reveal evidence of staff contacting Poison Control or researching signs/symptoms of laundry detergent poisoning at the time of Resident 222's suspected ingestion of the laundry detergent pod contents. Review of Resident 222's emergency room notes revealed: Reported to be found by staff at 1500 today with an open bag of laundry detergent pods next to him [Patient] reported to be vomiting and having diarrhea-unknown time of onset EMS dispatched at 2113 for a poisoning- arrived at 2123 to find [patient] 78% on Room air [(normal is 95-100%] , sitting up in a recliner slumped over. [Patient] arrives on nebulizer, slumped forward, emesis [(vomit)] bag with bright orange emesis with odor of detergent. Review of Resident 222's discharge summary from the hospital on November 29, 2023, revealed the resident was admitted to the ICU on high flow nasal cannula oxygen, placed on IV fluids and IV antibiotics, had a chest x-ray that showed aspiration (when fluids or stomach contents are breathed into the lungs), placed on bronchodilators (medications that relax the muscles around your airways and help clear mucus from your lungs) every 4 hours, and required frequent suctioning. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Interim Nursing Home Administrator and Corporate Nurse on March 15, 2024, at 9:35 a.m. when the above information was presented for staff failed to ensure a safe environment for cognitively impaired Resident 222 from ingesting laundry pod contents and timely assess, monitor, and treat suspected poisoning. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa Code 211.5(f) Clinical Records 28 PA Code 211.10(a) Resident care policies

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on review of the facility's policy, clinical records, and staff interview, it was determined that the facility failed to ensure the resident's weights were appropriately monitored and significant weight loss was timely addressed for two of 22 residents reviewed (Resident 3 and 67). Findings include: Review of the facility's policy titled Weights and Heights, dated June 15, 2022, revealed patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Hospital weights will not serve as admission or re-admission weight. Review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE]. Further review of Resident 3's clinical record failed to reveal any weights obtained from the time of admission through the duration of the survey (March 15, 2024.) Review of Resident 3's progress notes revealed a nutrition note dated February 26, 2024, which stated: admission weight pending, Most recent hospital weigh of 156 [pounds.] Interview with Dietitian, Employee 5 on March 15, 2024, at 11:20 a.m. confirmed the facility should have obtained an admission weight, then weekly weights on Resident 3, and using the hospital weight was not acceptable. Review of Resident 67's clinical record revealed Resident 67 was admitted to the facility on [DATE], with a diagnosis of Sepsis (Infection in the blood). Review of the weights and vitals revealed an initial weight of 225 pounds taken on November 21, 2023. The resident weight taken on November 22, 2024, revealed a weight of 225 pounds. On November 30, 2023, the resident's weight was 184.7 pounds, a 40.4 pounds (17.91%) significant weight loss in eight days. Review of Resident 67's clinical record failed to reveal that Resident 67's weight was re-checked after a significant change was identified on November 30, 2023. The records also failed to reveal that the physician was notified of the significant weight loss. Review of Resident 67's clinical record revealed Resident 67's significant weight loss identified on November 30, 2023, was not addressed by the dietitian until December 13, 2023. A dietary note dated December 13, 2023, revealed resident intake was documented at 100% but the patient stated that he only eats about 50%. Ensure Supplement three times daily was recommended. Interview conducted with Employee E3 on March 15, 2024, at 1:00 p.m., confirmed Resident 67's significant weight change identified on November 30, 2023, was not addressed until 13 days after. 28 Pa. Code 211.5(f) Clinical Records (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa Code: 211.10(c) Resident care policies

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 41765 Based upon review of staffing records and performance reviews it was determined the facility failed to ensure performance reviews were completed for five of five staffing records reviewed, (E6, E7, E8, E9, E10). Findings include: Review of staffing records and performance reviews revealed five staff members, E6, E7, E8, E9 and E10, did not have annual performance reviews performed within the appropriate timeframe. Interview with the Corporate Nurse on March 15, 2024, at 2:27 p.m. confirmed staff performance reviews were not completed timely. Further interview with Corporate Nurse a performance plan has been made to catch up on past due staff performance reviews. 28 Pa. Code 201.20(a)(c) Staff Development

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on clinical record and pharmacy record reviews, and staff interview, it was determined that the facility failed to ensure residents were free from significant medication error for three of the 22 residents reviewed (Residents 3, 67, and 81). Findings include: Review of Resident 3's clinical record revealed a diagnosis of seizure disorder (a sudden, uncontrolled burst of electrical activity in the brain that can affect behavior, movements, feelings and consciousness.) Review of Resident 3's physician orders from admission revealed an order for Phenytoin (medication used to control and prevent seizures) 100 milligrams (mg) once daily in the morning and 200 mg at bedtime. Review of Resident 3's March 2024 Medication Administration Record (MAR) and progress notes revealed the resident missed Phenytoin doses due to awaiting pharmacy delivery on the following dates: March 10, 2024, 100 mg in the morning March 11, 2024, 100 mg in the morning and 200mg at bedtime March 13, 2024, 100 mg in the morning March 14, 2024, 100 mg in the morning March 15, 2024, 100 mg in the morning Review of the pharmacy documentation revealed Phenytoin was available on the facility's automated dispensing machine (Omnicell). Interview with the Director of Nursing on March 15, 2024, at 2:30 p.m. confirmed Resident 3 should have received the abovementioned doses of Phenytoin. Review of Resident 67's clinical record revealed Resident 67 was readmitted on [DATE], with Osteomyelitis (Infection to the bone) on the sacrum (tailbone). Review of Resident 67's physician's order sheet (POS) dated January 26, 2024, at 7:38 p.m., revealed an order for Piperacillin Sod-Tazobactam (Antibiotic) Intravenous Solution 3.375 gm intravenously every six hours for wound infection. The medication administration was scheduled every 6:00 a.m., 12 noon, 6:00 p.m. , and 12:00 a.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 67's January 2024 Medication Administration Record (MAR) revealed Resident 67 was not administered the ordered medication until January 28, 2024, at 6:00 p.m. The MAR revealed Resident 67 missed seven doses of the ordered Piperacillin (January 27, 2024, at 12:00 a.m., 6:00 a.m., 12 noon, 6:00 p. m., January 28, 2024, at 12:00 a.m., 6:00 a.m., and 12 noon). Review of Resident 67's pharmacy documentation revealed medication Piperacillin was available on the facility's automated dispensing machine (Omnicell). Review of Resident 67's clinical record failed to reveal the reason why medication was not administered. Interview with Employee E3 was conducted on March 15, 2023, at 1:00 p.m. Employee E3 was not able to provide a reason as to why medication Piperacillin was missed seven times. The facility failed to ensure Resident 67's medication to treat wound infection was administered as ordered. Review of Resident 81's clinical record revealed Resident 81 was admitted to the facility on [DATE], with an infected surgical wound to the mid-upper back. The resident had an order for Intravenous (Medication administered into a vein) Vancomycin (antibiotic) and Vancomycin trough (a Vancomycin check at least eight hours after the last dose). Review of Resident 81's physician order revealed an order for Vancomycin HCL intravenously two times a day, scheduled at 9:00 a.m., and 9:00 p.m. Review of Resident 81's laboratory results dated [DATE], reported at 8:24 p.m., revealed a critical Vancomycin trough result of 27.7 (normal range 10-20). Review of Resident 81's nursing progress notes dated March 1, 2024, at 3:22 a.m., revealed on call NP (nurse practitioner) was notified of the critical Vancomycin trough result and ordered to hold the IV Vancomycin, recheck Vancomycin level in the morning before next administration and have the in-house physician/NP see the resident and review blood work in the morning. Review of Resident 81's NP's telehealth notes dated March 1, 2024, at 6:07 a.m., revealed laboratory result was reviewed, the Vancomycin trough was 27.7, recommended holding Vancomycin, repeating the Vancomycin trough, and checking the result before the next dose. Review of Resident 81's physician order dated March 1, 2024, at 3:48 a.m., revealed an order for Vancomycin through, check result before IV administration. Review of Residente 81's March 2024, Medication Administration Record (MAR) revealed Resident 81's IV Vancomycin was not administered on March 1, 2024, at 9:00 a.m., but was administered on March 1, 2024, at 9:00 p.m. Review of Resident 81's clinical record failed to reveal a Vancomycin trough level was done/checked before administering the IV Vancomycin on March 1, 2024, at 9:00 p.m. (continued on next page)

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	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehabilitation Exto	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 - Minimal harm or potential for actual harm Residents Affected - Some	Review of the NP's progress notes dated March 2, 2024, at 4:29 p.m., revealed a Medication Error, The resident's Vancomycin trough was 27.7 on February 29, 2024, the note stated to hold Vancomycin and ordered Vancomycin trough. Per the nurse, it was not held, Vancomycin was given, and laboratory was not done. Interview with Employee E3 on March 15, 2024, at 1:00 p.m., confirmed that Vancomycin was administered as documented in MAR. There was no incident report/statements completed for the medication error incident, the nurse involved no longer works in the facility. The facility failed to ensure Resident 81's Vancomycin medication was administered as ordered. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41765 Based on review of staffing records and interviews with staff, it was determined the facility failed to perform the minimal 12 hours of annual training for five of five staffing records reviewed, (Employees E6, E7, E8, E9 and Employee E10). Findings include: Review of staffing records failed to reveal the minimal 12 hours of annual training for five staff members reviewed, Employees E6, E7, E8, E9 and Employee E10. Interview with the Corporate Nurse (E3) on March 15, 2024, at 2:27 p.m. confirmed staff did not receive the minimal 12 hours of annual training. Further interview with Corporate Nurse E3 confirmed a performance plan has been made to catch up on past due staff training. 28 Pa. Code 201.20(a)(c) Staff Development