

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39A435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Southeastern Pennsylvania Veteran's Center		STREET ADDRESS, CITY, STATE, ZIP CODE One Veterans Drive Spring City, PA 19475	
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** Based on a review of the facility's policy, observation, and interviews with residents and staff, it was determined that the facility failed to ensure the resident was administered the correct medications for one of three residents reviewed (Resident 1). The error resulted in harm and hospitalization due to the medications' side effects. This was a past non-compliance. Findings include: A review of the facility's policy and procedure titled Medication Administration, dated May 1, 2025, revealed that the licensed nurse preparing the medications for administration will follow the six rights of medication administration: right resident, right medication, right dose, right route, right time, and right documentation. The same policy also revealed that residents are identified before medication is administered. Methods of identification include checking identification bands, reviewing photographs attached to medical records, calling residents by name, and, if necessary, verifying resident identification with other facility personnel. A review of Resident 1's diagnoses list includes Diabetes (a group of metabolic disorders characterized by a high blood sugar level over a prolonged period of time), hypertension (high blood pressure), prostate cancer, and congestive heart failure (CHF, A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). A review of Resident 1's Quarterly Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated July 10, 2025, revealed resident was cognitively intact. On September 17, 2025, at 9:45 a.m., Resident 1, was observed sitting on their chair, and reported that a few months ago, a female staff member gave them morning medications. Resident 1 reported questioning the number of pills in the cup, but the staff told them to take it, so they followed the instructions. Resident 1 reported they were sent to the hospital the same day as the incident. A review of the nursing progress notes dated September 9, 2025, at 12:47 p.m. revealed the Unit nurse administered peer's medication to resident at 11:12 a.m., including Bisacodyl 5 mg (a medication to soften the stool), Chlorpromazine 10 mg (Anti-psychotic medication), Diltiazem 120 mg (a medication used to treat high blood pressure), Duloxetine 60 mg (a medication used to treat depression), Loratadine 10 mg (a medication used to treat allergies), Oxybutynin 5 mg (a medication used to treat overactive bladder), Pantoprazole 40 mg (a medication used to decreased the amount of acid in the stomach), Senna Plus 2 tabs (a stool softener), Tramadol 50 mg (a controlled medication used to treat moderate to severe pain), and Vraylar 1.5 mg (Anti-psychotic medication). The same note revealed that the resident was assessed, denied nausea, pain, sedation, and other ill effects. Family and physicians were notified and ordered to hold Resident1's scheduled antihypertensive medications. A review of the physician's notes dated September 9, 2025, at 12:16 p.m., revealed Accidental ingestion of medication-advice monitor full vitals, concerns for abdominal side effects and sedation, and over treatment of bp (blood pressure)-patient educated on possible side effects, may experience it in 3-4 hours or may not have any side effects. A review of the nursing progress notes dated September 9, 2025, at 5:58 p.m., revealed the resident was assessed after a report from the family that the resident was pale with nausea and had vomited. Vitals as follows: blood pressure - 122/60 mmHg (millimeters of mercury), heart rate-56/min, respirations- 18/min. The resident was served dinner but vomited after a few bites. The physician was notified with orders to transfer the (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 0760 Level of Harm - Actual harm Residents Affected - Few	resident to the hospital. A review of the hospital Discharge summary dated [DATE], revealed that Hospital Problem List was lightheadedness, ingestion of unknown medications, nausea, and vomiting. admission diagnosis was Medication side effects, near syncope. Clinical record review revealed Resident 1 was returned to the facility on September 12, 2025. A review of the physician's admission notes dated September 12, 2025, at 2:20 p.m., revealed that the resident was admitted (to the hospital) for observation from September 9, 2025, until September 12, 2025, with a diagnosis of near syncope, medication side effect, nausea, and vomiting. The same note revealed the resident was sent to the hospital due to nausea, vomiting, and fatigue after being given another patient's medication. The patient received Intravenous (administered in the vein) fluids and a bowel regimen for constipation (hard stool). The patient has transient bradycardia (a temporary decrease in heart rate that lasts for a short period) likely from Diltiazem. A review of the facility's documentation revealed that a facility investigation was completed on September 9, 2025, related to Medication Discrepancy. A review of a statement from licensed nurse Employee E3, dated September 9, 2025, revealed During med pass, this nurse was prepared to administer medications to (the intended recipient) when I realized I had already given them the medications to (Resident 1). The same statement revealed that when Employee E3 initially entered Resident 1's room, there were two other residents in the room, the roommate and another resident visiting their room. Employee E1 reported that when they called Resident 1's last name, the resident answered Yes, so they proceeded with the medication administration. Employee E3 also reported that Resident 1 was laughing and talking with the other two residents, that they must not have heard Employee E3. Nursing supervisor was notified upon learning about the mistake, the resident was assessed, family and the physician were notified. An interview conducted with the Director of Nursing on October 7, 2025, at 11:00 a.m., revealed that Employee E3 was not Resident 1's regular nurse. A review of the facility's plan for correction included the following: Resident's condition was monitored and assessed. Medication competency completed on nurse who completed the medication error. Residents' photos to be updated for those who have resided here greater than one year. Name bands to be created and applied to all residents. All licensed staff scheduled will have medication competency completed prior to start of their first med pass, PRN staff, light duty and nurses on FMLA will complete competency upon return to work before first med pass. The ADON/designee will audit five random residents' medication administration pass and verify weekly for three months to ensure compliance. Findings will be reported in the monthly Quality Assurance and Performance Improvement (QAPI) meetings. The facility's plan of correction was completed on September 15, 2025. A medication administration observation completed on October 7, 2025, a review of the facility's education/training, recorded audits, and staff interviews confirmed completion of the facility's plan of correction. The above was conveyed to the Commandant and Director of Nursing on October 7, 2025, at 2:00 p.m. The facility failed to ensure Resident 1 was free from a significant medication error, which resulted in the harm of being hospitalized due to the medication side effects. 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 7/1/25, 5/9/25 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 7/1/25, 5/9/25 28 Pa. Code 201.18(e)(3) Management Previously cited 7/1/25, 5/9/25 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services Previously cited 7/1/25, 5/9/25 6/14/24, 3/16/24		