STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395740	A. Building B. Wing	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Chester Rehabilitation and Healthcare Center	800 West Miner Street West Chester, PA 19382

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30934 Based on clinical record review, facility documentation review, facility policy and procedure review, and staff interview it was determined the facility failed to report an allegation of abuse to the state agency for one of 8 residents reviewed. (Resident 133) Findings Include: Review of facility policy and procedure titled Abuse Prohibition, undated, revealed Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee will perform the following. Report allegations to the appropriate state and local authority(s) involving neglect, exploitation, or mistreatment. Review of Resident 133's progress notes revealed a nursing progress note dated February 19, 2022 stating this nurse knocked on residents door entered at 9:30 a.m. observed resident laying on floor on right side of bed in prone position with right arm wedged under himself. Review of facility incident report dated February 19, 2022, revealed Resident 133 was found on the floor in his room bedside his bed on his right side of the bed prone position with right arm underneath him. He reported that he fell attempting to walk himself to the bathroom. Review of Fall Review Statement obtained from the staff at the time of the fall revealed the statement of Employee E3 stating Resident 133 was found on the floor face down with dried blood and feces all over his body this morning while doing rounds. My supervisor later came in to ask how long he has been on the floor, and he responded since 2 a.m. three times. Review of further documentation provided by the facility revealed that the incident was fully investigated for neglect. Review of the Electronic Event Report, dated February 19, 2022, submitted to State Agency revealed the event was reported as a transfer to the hospital not as an allegation of abuse. Review of the description of the event revealed no information regarding Resdient 133's allegation he was on the floor since 2 a.m. and covered in dried feces and blood. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator and the Director of Nursing on June 17, 2022, at 1:00 p.m. confirmed the event was not reported to the state agency correctly as an allegation of neglect. 28 Pa. Code: 201.18(b)(1)(e)(1) Management 28 Pa. Code: 201.29(d) Resident rights 28 Pa. Code: 211.10(a) Resident care policies

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41765 Based on a review of the facility's policy, clinical records review, and staff interviews, it was determined that the facility failed to timely develop a comprehensive care plan regarding a fall for one of 32 residents reviewed (Resident 37) Findings include: Review of the facility's policy titled Falls Management revealed that all patients will be assessed for risk of falls upon admission, with reassessments routinely performed to determine the ongoing need for fall prevention precautions. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Review of Resident 37's diagnosis list revealed Dementia (term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), generalized weakness, abnormalities of gait and mobility, and fracture of the left femur (thigh bone). Review of Resident 37's Admission Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated January 14, 2022, revealed that the resident had severe cognitive impairment. Review of Resident 37's nursing documentation dated January 1, 2022, at 7:11 p.m., revealed resident was a new admission with a health history of falls, Dementia, and Seizures (sudden, uncontrolled electrical disturbance in the brain). It also revealed that the resident was alert but oriented only to the person. ADL (activity of daily living) review revealed resident had a limitation to the left leg and required limited assistance with transferring, locomotion, and ambulation. The same documentation revealed a fall risk was identified for Resident 37; a low bed was checked as a device in use and was reviewed. Review of the NP's (Nurse Practitioner) progress notes dated January 3, 2022, revealed resident was seen for new admission for continued rehab and was initially admitted from another rehab facility following a fall at home that resulted in a left hip fracture requiring total hip arthroplasty (A surgical procedure to restore the function of the joint). Review of a general note dated January 6, 2022, at 12:02 a.m., revealed Resident 37 was found on the floor by the NA (nursing assistant), nurse was called, resident was observed sited at the side of the bed, guarding the left hand, crying of pain to the left hip as well. The same note indicated that the resident was assessed, the left wrist was observed out of place, MD was notified, and the resident was transferred to the hospital via 911 for a possible left wrist fracture. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility documentation, Event Summary Report, revealed the incident occurred on January 5, 2022, at 9:50 p.m. The event indicated that the resident was found on the floor by the NA, guarding their left hand and crying. During the assessment, the resident's left wrist appeared out of place, MD was notified and ordered to transfer the resident to the hospital via 911. The investigation revealed that before the fall, the resident was placed in a direct line of sight to avoid impulsiveness, the injury did not occur until the resident was placed in bed for the night, and the NA had just walked out of the room after securing resident into bed when she fell . The same note revealed resident was out of the low bed to the floor/mat. Review of a general note dated January 6, 2022, at 7:17 a.m., revealed resident was admitted to the hospital with Syncope. Review of Resident 37's plan of care revealed falls care plan was initiated on January 6, 2022, a day after Resident 37 had an unwitnessed fall sustaining a left wrist fracture. An interview with the Director of Nursing (DON) on June 17, 2022, at 1:00 p.m., confirmed Resident 37's fall care plan was not developed until January 6, 2022, a day after the resident had a fall. The facility failed to timely develop a comprehensive fall care plan for Resident 37. 28 Pa. Code 211.10(c) Resident Care Policies Previously cited 5/6/2021 28 Pa. Code 211.5(h)Clinical records Previously cited 5/6/21 28 Pa. Code 211.12(d)(5) Nursing Services Previously cited 5/6/21 28 Pa. Code 211.12(d)(1)(3) Nursing Services Previously cited 5/6/21 28 Pa. Code 211.12(c) Nursing Services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on review of clinical records and facility documentation, as well as staff interviews, it was determined that the facility failed to address a suspected right femur (thigh bone) non-displaced fracture (the bone breaks but retains its proper alignment) timely as evidenced by a radiology report. This failure had resulted in harm of unnecessary discomfort, pain, and hospitalization for one of 32 residents reviewed (Resident 101). Findings include: Review of Resident 101's diagnosis list revealed Cerebrovascular Accident (stroke), and Hemiplegia (paralysis of one side of the body). Review of Resident 101's Quarterly Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated October 22, 2021, revealed that the resident had moderate cognitive impairment. Further review of the same MDS assessment revealed the resident required supervision with transferring and ambulation on and off the unit. Review of the nursing documentation notes dated January 10, 2022, at 3:12 p.m., revealed Resident 101 was very anxious about not being in her/his assigned room during quarantine with COVID-19 virus. The same note further revealed the resident was confused, oriented to person, and moderately impaired with decision making. The resident's walking was not steady but able to stabilize without staff assistance. Review of the nursing documentation notes, dated January 11, 2022, at 6:58 p.m., revealed Resident 101 had a change in ambulation status, would not ambulate, and required staff assistance with standing and transferring into the wheelchair. The NP (Nurse Practitioner) was made aware. Review of the nursing documentation notes dated January 11, 2022, at 7:03 p.m., revealed, the resident was transferred by the nurse, upon attempt, the resident would not stand, and would bear weight on both legs when standing but was unsteady due to leaning to the left (leg). A small dime-sized bruise was observed on the left knee, with no grimacing during the assessment. Review of the Physician Order Sheet (POS) dated January 11, 2022, at 7:49 p.m., revealed an order for a Stat (immediate) X-ray of the right knee and femur related to pain and swelling. Review of the Radiology Result Report dated January 11, 2022 (11:43 p.m.) revealed the following: Right knee had modest osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), no acute fracture or dislocation. The right femur x-ray result report revealed a suspicious non-displaced femoral neck impaction fracture. The same report revealed, Please correlate clinically and follow-up is recommended to confirm or exclude this diagnosis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse Practitioner's progress note dated January 12, 2022, revealed the resident was seen for follow-up after a recent COVID positive test result and complaint of right knee pain. The note further indicated that during the examination the resident was labile [frequently changing] at baseline. The same note revealed that the resident had right knee pain and was having difficulty standing unless with assistance. The knee was swollen but not warm to touch, the resident grimaced when the right knee was moved, and the right knee had a bruise. The note also revealed the resident reported falling three times (no dates or times indicated) while in another room. The NP's note had documentation of the right knee x-ray result of January 11, 2022, but failed to indicate documentation of the right femur x-ray result. Review of the POS revealed Resident 101 was ordered Ibuprofen (medication used to treat pain and swelling) 400 mg (milligrams) two times daily for right knee inflammation and pain. Review of the nursing documentation notes dated January 15, 2022, at 2:29 p.m., revealed Resident 101's right knee was still swollen, and resident continued to have difficulty bearing weight on the right leg. Review of the nursing documentation notes dated January 17, 2022, at 3:41 p.m., revealed resident had bilateral lower extremity (BLE) pain. On January 18, 2022, Resident 101 was seen by attending physician with documentation revealing resident had a right knee inflammation and was on Ibuprofen. The physician's notes did not mention anything regarding the resident's right femur x-ray result reported to the facility on [DATE]. Review of the NP's progress notes dated January 20, 2022, revealed Resident 101 was seen for continued right knee pain. The note revealed resident complained of the right knee and was having difficulty standing and walking unless with assistance. The right knee was swollen, and the resident was able to move bilateral knees but grimaces when the right knee was moved. An Orthopedic (Physician that specializes in musculoskeletal system) consult was ordered for non-improved pain. Review of the physician notes dated January 21, 2022, revealed [Resident 101] had been complaining of right knee pain and had been having trouble standing as per nursing. The same note revealed right knee pain, no evidence of gout, no swelling, and an x-ray unrevealing the acute cause. An order for Ibuprofen and Tramadol (medication used to treat moderate pain) was made. As per physician note, attempts for an Ortho consult were made but were unsuccessful due to insurance, the resident will be reassessed. There was no mention/documentation of the resident right femur x-ray result. Review of the NP's notes dated January 26, 2022, revealed resident was still complaining of right knee pain. The same note indicated that as per discussion with the nursing assistant (NA), the NP was informed that the resident was able to stand with assistance but yells in pain when attempting to sit in the toilet. An X-ray of the right hip was ordered. Review of the Radiology Result Report dated January 26, 2022, at 10:42 a.m., revealed an acute, mildly displaced right femoral neck fracture (gap that forms where the bone breaks). Review of the progress notes dated January 26, 2022, at 1:49 p.m., revealed Resident was transferred to the hospital for a mild displaced right hip fracture. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Hospital records review dated January 26, 2022, revealed Resident 101 was admitted to the hospital with a diagnosis of a closed displaced fracture of the right femoral neck. Assessment and plan revealed, unclear when the hip fracture occurred, sometime in last two weeks. Ortho consults and pain management was ordered. Review of the NP's progress notes dated February 2, 2022, revealed resident was readmitted to the facility. The same note revealed Resident 101 had a Right Hemiarthroplasty (surgical procedure that involves replacing half of the hip joint) on January 28, 2022. Interview with the Director of Nursing (DON) was conducted on June 17, 2022, at 11:45 a.m. The DON reported that radiology results can be accessed electronically. As per the Director of Nursing, nurses and/or supervisor checks the result and notifies the physician. The Nurse Practitioners can also view the radiology results electronically. Clinical records review failed to reveal that the physician/NP were notified of the right femur x-ray result on January 11, 2022, indicating suspicions of a non-displaced femoral neck impaction fracture. Interview with the Nurse Practitioner (NP) was conducted on June 17, 2022, at 11:45 a.m. The NP reported that on January 11, 2022, she/he only saw a right knee x-ray result, the NP stated, It might not have been there yet when I checked the result, I copied the result and pasted it to my notes The NP confirmed that she was not aware of the right femur x-ray result reported to the facility on [DATE]. When asked what she would have done if she had known the right femur x-ray result, the NP stated, I would have sent the resident to the hospital. The above information was discussed with the Nursing Home Administrator and Director of Nursing on July 17, 2022, at 1:00 p.m. The facility failed to address a right femur x-ray result that showed Resident 101 with a suspicious non-displaced femoral neck impaction fracture for 15 days which resulted in continued pain in right leg, hospitalization , and surgery. 28 Pa. Code 201.18 (b)(1)(e)(1) Management Previously cited 3/3/22, 10/22/21, 5/6/21 28 Pa. Code 211.5(h)Clinical records Previously cited 5/6/21 28 Pa. Code 211.12(d)(5) Nursing Services Previously cited 5/6/21 28 Pa. Code 211.12(d)(1)(3) Nursing Services Previously cited 5/6/21 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12(c) Nursing Services

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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. 37789 Based on reviews of facility policy, clinical records, and staff interview, it was determined that the facility failed to adequately monitor and address weight loss for two of 12 residents reviewed for nutrition (Residents 40 and 70.) Findings include: Review of facility policy, Weights and Heights, last revised June 1, 2021, revealed that when weighing a resident, If the body weight is not as expected, re-weigh the [resident.] Further review of the policy revealed that when a resident experiences a significant weight change, The interdisciplinary care plan will be updated to reflect the individualized goals and approaches for managing the weight change. Review of Resident 40's weights revealed that on May 10, 2022, the resident weighed 118.2 pounds (lbs.) On June 3, 2022, the resident weighed 109.5 lbs., a 7.36% weight loss in one month. Further review of Resident 40's weights failed to reveal a reweight following the June 3, 2022 weight. Review of Resident 40's progress notes revealed a nutrition note dated June 16, 2022, which stated: Resident on hospice care, [weight] loss likely inevitable. Ensure resident's food & beverage preferences are up to date & continue comfort/supportive nutrition interventions. Recommend re-weight to confirm weight loss. Clinical record review and interview with the Nursing Home Administrator and Director of Nursing on June 17, 2022, at 2:50 p.m. confirmed that Resident 40 had been discharged from hospice care on May 19, 2022. The facility's failure to reweigh Resident 40 and the inaccurate documentation that the resident was on hospice when the weight loss occurred was confirmed at this time. Review of Resident 70's weights revealed that on May 2, 2022, the resident weighed 148 lbs. On June 2, 2022, the resident weighed 137.5 pounds which is a -7.09 % loss in one month. Further review of Resident 70's weights failed to reveal a reweight to confirm the accuracy of the weight loss. Interview with the Nursing Home Administrator and Director of Nursing on June 17, 2022, at 1:06 p.m. confirmed the facility did not reweigh Resident 70 to confirm the accuracy of the resident's weight loss. 28 Pa. Code 211.5(f) Clinical RecordsPreviously cited 5/6/2021, 8/31/2020 28 Pa. Code 211.10(c) Resident Care PoliciesPreviously cited 5/6/2021 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services Previously cited 1/11/2022, 10/4/2021, 8/12/2021, 5/6/2021, 2/8/2021, 8/31/2020

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37789 Based on clinical record review, it was determined the facility failed to respond to recommendations made by the consultant pharmacist for four of five residents reviewed for unnecessary medications (Residents 24, 34, 81, and 133). Findings include: Review of Resident 24's physician's orders revealed an order dated August 4, 2021, for Alprazolam (Xanax - medication used to treat anxiety) 0.25 milligrams (mg) - give one tablet by mouth every 12 hours as needed for anxiety. Review of Resident 24's pharmacy consultation report dated August 23, 2021 revealed Resident 24 has a PRN order for an anxiolytic [(antianxiety medication)], without a stop date. The consultation recommended: Please add a 14 day stop date to the order with re-evaluation. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Further review of Resident 24's August 23, 2021 pharmacy consultation failed to reveal that the physician addressed the recommendation. Further review of Resident 24's pharmacy consultation report dated September 25, 2021, revealed a repeated recommendation from the August 23, 2021 pharmacy consultation. Further review of the September 25, 2021 pharmacy consultation failed to reveal that the physician addressed the recommendation. The facility's failure to respond to the pharmacist's recommendations for August and September 2021 for Resident 24 was discussed and confirmed with the Nursing Home Administrator and Director of Nursing on June 17, 2022 at 1:07 p.m. Review of Resident 34's Progress Notes revealed the resident's clinical record was reviewed by the consultant pharmacist with recommendations made on April 22, 2022, March 30, 2022, February 24, 2022, and January 20, 2022. The facility was asked to provide the report from the consultant pharmacist on the above date on June 16, 2022, and documented evidence the physician acted upon pharmacist recommendations made on above mentioned dates. Interview with the Nursing Home Administrator and the Director of Nursing on June 17, 2022, at 1:00 p.m. revealed the facility was unable to provide those reports to the surveyor or provide documented evidence the recommendations made by the pharmacist were acted upon by the physician for the irregularities found on April 22, 2022, March 30, 2022, February 24, 2022, and January 20, 2022. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 81's progress notes revealed resident's clinical record was reviewed by the pharmacy consultant and recommendations were made on January 29, 2022, March 17, 2022, and May 16, 2022, to clarify the diagnosis used to justify need for Haldol (antipsychotic medication). Review of same notes revealed Resident 81's diagnosis used for usage justification for the Haldol medication was agitation and aggression. Review of Resident 81's clinical records revealed pharmacy recommendations made on January 29, 2022, March 17, 2022, and May 16, 2022, were not acted upon until May 22, 2022. Interview with the Director of Nursing on June 17, 2022, at 1:15 p.m., revealed and confirmed the facility was unable to provide documented evidence that recommendations made on the above-mentioned dates were acted upon by attending physician until May 22, 2022. Review of Resident 133's progress notes revealed the Consultant Pharmacist made recommendations on the resident's medication regimen on December 26, 2021, and September 26, 2021. Review of the Consultation Reports on these dates revealed they were not addressed by the physician. Review of Resident 133's clinical record revealed there was no evidence Resident 133's Consultant Pharmacist Recommendations of September 25, 2021, and December 26, 2021, were acted upon by the attending physician. The facility's failure to respond to the pharmacist's recommendations for December and September 2021 for Resident 133 was discussed and confirmed with the Nursing Home Administrator and Director of Nursing on June 17, 2022 at 1:07 p.m. 28 Pa. Code 211.5(f) Clinical recordsPreviously cited 5/6/2021, 8/31/2020 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing servicesPreviously cited 1/11/2022, 10/4/2021, 8/12/2021, 5/6/2021, 2/8/2021, 8/31/2020

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37789 Based on clinical record review, it was determined that the facility failed to ensure that PRN (as needed) orders for psychotropic medications were limited to fourteen days for one of five residents reviewed for unnecessary medications (Resident 24). Findings include: Review of Resident 24's clinical record revealed a diagnosis of anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 24's physician's orders revealed an order dated August 4, 2021, for Alprazolam (Xanax - medication used to treat anxiety) 0.25 milligrams (mg) - give one tablet by mouth every 12 hours as needed for anxiety. Review of Resident 24's pharmacy consultation report dated August 23, 2021 revealed Resident 24 has a PRN order for an anxiolytic [(antianxiety medication)], without a stop date. The consultation recommended: Please add a 14 day stop date to the order with re-evaluation. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Further review of Resident 24's August 23, 2021 pharmacy consultation failed to reveal that the physician addressed the recommendation. Further review of Resident 24's pharmacy consultation report dated September 25, 2021, revealed a repeated recommendation from the August 23, 2021 pharmacy consultation. Further review of the September 25, 2021 pharmacy consultation failed to reveal that the physician addressed the recommendation. Review of Resident 24's Medication Administration Records (MARs) from August 2021, September 2021, and October 2021, revealed the resident continued to receive PRN Alprazolam 0.25 mg from August 4, 2021 through October 4, 2021. The facility's failure to ensure Resident 24's PRN psychotropic medication was limited to 14 days was discussed and confirmed with the Nursing Home Administrator and Director of Nursing on June 17, 2022, at 1:07 p.m. 28 Pa. Code 211.2(a) Physician servicesPreviously cited 5/6/2021 28 Pa. Code 211.12(d)(1)(3)(5) Nursing servicesPreviously cited 1/11/2022, 10/4/2021, 8/12/2021, 5/6/2021, 2/8/2021, 8/31/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395740	A. Building B. Wing	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Chester Rehabilitation and Healthcare Center	800 West Miner Street West Chester, PA 19382

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 - Few	Ensure that residents are free from significant medication errors. 41765 Based on clinical records review, resident, and staff interviews, it was determined that the facility failed to ensure residents were free from significant medication errors for two 32 residents reviewed (Residents 68 and 358). Findings include: Review of Resident 68's diagnosis list revealed Heart Failure, Hypertension (elevated blood pressure), and End-Stage Renal Disease (ESRD). Review of the physician's progress notes revealed Resident 68 is on Hemodialysis (treatment that filters waste and water from your blood) every Monday, Wednesday, and Friday for diagnosis of ESRD. Review of Resident 68's Physician Order (POS) dated June 2, 2022, revealed an order of Clonidine HCL (medication used to treat high blood pressure) tablet 0.1 mg (milligram) give one tablet every eight hours for hypertension only if blood pressure is above 180. Review of Resident 68's June 2022 Medication Administration Record (MAR) revealed that Clonidine medication was administered 15 times for blood pressure below 180. Interview with the Director of Nursing on June 17, 2022, at 1:00 p.m., confirmed that resident 68 was administered Clonidine outside of the physician's ordered blood pressure parameters. Review of Resident 68's POS dated June 2, 2022, revealed an order of Lokelma Packet (medication used to treat high levels of Potassium in the blood) give one packet by mouth once a day for Hyperkalemia (elevated potassium) only if Dialysis is missed. Review of June 2022, MAR revealed the medication Lokelma was administered on June 3, June 6, and June 9, 2022. Review of the clinical records review revealed no documentation of the resident missing dialysis between June 2 until June 17, 2022. Interview with the DON on June 17, 2022, at 1:00 p.m., confirmed that Resident 68 did not miss dialysis on the above-mentioned dates. Review of Resident 358's diagnosis list revealed Cancer of the prostate, ESRD, and dependence on Hemodialysis. Clinical records revealed Resident 358's Hemodialysis is every Monday, Wednesday, and Friday. Review of Resident 358's physician order sheet revealed an order on June 7, 2022, for Calcium Acetate Tablet (medication to treat excessive phosphate in the blood of a patient with end-stage kidney disease on dialysis) 667 mg given two tablets by mouth three times a day for high phosphates. Administration times were as follows: 9:00 a.m., 1:00 p.m., and 8:00 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 358's June 2022 MAR revealed Calcium Acetate medication was not administered to the resident on June 8, June 10, June 13, and June 15, 2022 at 1:00 p.m., the MAR was documented with code AW on the mentioned dates which indicated resident was away from the center. Interview with the DON on June 17, 2022, confirmed that ordered Calcium Acetate medication was not administered to the resident due to being at dialysis. The clinical record reviewed failed to reveal physician was notified of the missed medication doses due to the dialysis schedule. The above information was discussed with the Director of Nursing on June 17, 2022, at 2:00 p.m. The facility failed to ensure Resident 68 was free from a significant medication error. 28 Pa. Code 211.5(h)Clinical records Previously cited 5/6/21 28 Pa. Code 211.12(d)(5) Nursing Services Previously cited 5/6/21 28 Pa. Code 211.12(d)(1)(3) Nursing Services Previously cited 5/6/21 28 Pa. Code 211.12(c) Nursing Services