STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395289	A. Building B. Wing	09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at South Hills Rehabilitation and Nrsg Ctr	201 Village Drive Canonsburg, PA 15317

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility policy, documents, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for one of three residents (Resident R1). Findings include: Review of facility policy Administering Medications 1/18/24, indicated medications are administered in a safe and timely manner, and as prescribed. The policy further stated that the individual administering the medication records in the resident's medical record: -the date and time the medication was administered; -the dosage; -the route of administration; -the injection site (if applicable); -any complaints or symptoms for which the drug was administered; -any results achieved and when those results were observed; and -the signature and title of the person administering the drug. Review of Resident R1's admission record indicated he was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R1's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 8/2/24, included diagnoses of epilepsy (disorder of the brain characterized by repeated seizures) and non-traumatic brain dysfunction. Review of Resident R1's plan of care initiated 10/11/23, indicated Resident R1 is at risk for seizure activity. Included in the care plan interventions was, Medications as ordered. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician's order dated 4/26/24, then discontinued on 9/7/24, indicated for Resident R1 to receive 500 mg (milligrams) of levetiracetam (Keppra, an anti-seizure medication). Review of facility census information indicated Resident R1 was hospitalized from 8/9/24, until 8/21/24. Review of hospital discharge paperwork dated 8/20/24, indicated in the Final Medication List levetiracetam (Keppra 500 mg oral tablet) 2 tab(s) by mouth 2 times per day. Review of a progress note dated 8/23/24, at 1:58 a.m. indicated, CNA (nurse aide) alerted this Nurse to Pt (patient) having grand Mal seizure (a type of seizure that involves a loss of consciousness and violent muscle contractions). Nurse rushed in to find Pt convulsing without dilated pupils. Pt immediately rolled to L(left) side to conclude seizure activity while Nurse Supervisor was alerted. Seizure endured for 12 seconds before occurrence ended. VS (vital signs) 128/81, 104, 97% on RA, 97.0. Resps (respirations) shallow, even and labored. Neuro checks back to baseline post seizure. Pt gradually calmed down after Nurse supervisor entered room. Pt lethargic post seizure. MD alerted. Will continue to monitor. Review of a progress note dated 8/23/24, at 4:10 a.m. indicated Resident R1 was sent to the local hospital via ambulance. Review of hospital laboratory blood test results dated 8/23/24, collected at 4:46 a.m. indicated that Resident R1's level of levetiracetam level was less than 2.0 ug/mL (micrograms per milliliter). The normal level expected is referenced on this document as 10.0 - 40.0 ug/mL. Review of Resident R1's medication administration record (MAR) for August 2024 indicated Resident R1 received 500 mg of levetiracetam twice daily. During an interview on 9/7/24, at approximately 1:00 p.m. the Director of Nursing (DON) confirmed that when Resident R1 returned from the hospital on 8/21/24, the facility was experiencing an electronic medical record down time and produced a paper MAR (printed on 8/18/24) that indicated an order for levetiracetam 500 mg, twice daily. Handwritten next to the order was information that the order was changed to two tablets, twice daily. Administrations on this paper MAR were for 8/20/24, and 8/21/24. Review of the electronic MAR from 8/21/24, through 8/26/24, revealed the order was not updated in the medical record to reflect the change from one tablet (500 mg) twice daily, to two tablets (1000 mg) twice daily. Review of the electronic MAR indicated the administrations were ordered for 8:00 a.m. and 8:00 p.m. The following levetiracetam administrations were documented as provided: 8/21/24: 500 mg at approximately 8:00 p.m. 8/22/24: 500 mg at approximately 8:00 a.m. 8/22/24: 500 mg at approximately 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	8/23/24: Not provided due to Resident R1 being hospitalized . 8/23/24: 500 mg at approximately 8:00 p.m. 8/24/24: 500 mg at approximately 8:00 a.m. 8/24/24: 500 mg at approximately 8:00 p.m. 8/25/24: 500 mg at approximately 8:00 a.m. 8/25/24: 500 mg at approximately 8:00 p.m. 8/26/24: 500 mg at approximately 8:00 a.m. 8/26/24: Not provided due to Resident R1 being hospitalized . During an interview on 9/7/24, at approximately 2:00 p.m. the Director of Nursing confirmed that the physician's order in the medical record was not updated, and confirmed the MAR from 8/21/24, through 8/26/24, documented that 500 mg of levetiracetam was provided twice daily, rather than the updated dosage of 1000 mg twice daily. During an interview on 9/7/24, at approximately 2:00 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents were free from significant medication errors for one of three residents. 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa Code 211.12(d)(1)(3)(5) Nursing Services.