STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395495	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrooke Court-Spring Hous	728 Norristown Road Lower Gwynedd, PA 19002

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on review of the facility policies, facility documentation, and staff interviews, it was determined that the facility failed to implement procedures to promote accurate narcotic medication records on one of one medication storage room reviewed. (Pine nursing unit) Finding include: Review of the facility policy on Storage and Expiration Dating of Medications, Biologicals, revised on August 7, 2023, indicated that facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security. Review of clinical records of Resident R59, revealed that the resident was admitted to the facility on [DATE], with diagnoses including adult failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments). Review of Resident R59, January 2024 physican orders revealed an order January 4, 2024 for the anti-anxiety medication Lorazepam Intensol Oral Concentrate 2 MG/ML, give 0.25 ml, 0.5 mg, by mouth every 6 hours as needed for anxiety for 14 days. A review of facility investigation report revealed that on Friday January 5, 2024, nursing received a 30 ml bottle of liquid Ativan for the resident. It was received in a sealed bottle. No dose of Ativan were given to the resident on January 5th,6th, or 7th of 2024. The registered nurse working the 11-7 shift on January 7th, 2024, into January 8th, 2024, stated that she went to give a dose to the resident during the night; however, noticed that the bottle appeared to have been tampered with and was missing 14 MLs of medication. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the investigation report indicated that, obtained staff statements. Narcotic count was completed at the start of the 11-7 shift on January 7, 2024; however, the oncoming nurse (11-7) failed to go to the refrigerator with the 3-11 nurse to check the Ativan vial. The 3-11 nurse assumed she checked the Ativan because she came and signed off on the controlled drug inventory sheet that the count was correct. The 3-11 nurse reports that the vial of Ativan was full. The 3-11 and 11-7 nurses both report that the medication keys were never out of their possession. The 11-7 nurse is unable to provide an account of what occurred with the missing Ativan as she did not verify the contents at the start of her shift. She stated that she realized there was a problem with the vial when she went to get it from the refrigerator to administer to the resident. Toxicology screen completed for the nurse who reported the missing medication and was negative for Benzodiazepams. The 11-7 nurse is the presumed perpetrator; however, facility cannot definitively conclude that she was responsible for the missing Ativan. Facility was able to substantiate that she failed to follow the policy for completing the controlled drug inventory. Audit of all controlled substances in the facility was completed and no other medications were compromised. Interview with the Director of Nursing (DON) on May 28, 2023, at 10:07 a.m., confirmed the above stated findings. Review of the statement dated January 8, 2024, of Employee E10, a Registered Nurse, indicated as follows: I attempted to give room [ROOM NUMBER], Ativan liquid from the locked drawer, in the fridge. When I opened the box, med bottle had been opened; screw type insert was present (used for MSO4, not Ativan), and a couple of pieces of the safety paper noted under insert. The correct dropper for Ativan was present and sealed. Upon closer inspection, noted 16 cc of medicine in the bottle (should be 30 cc). Medicine was not given to resident due to tampering. DON aware. I admit I never checked medicine during narcotic count with previous Shift. Sorry . On May 28, 2024, at 10:40 a.m., tried to interview Employee E10, over telephone, but the attempt did not result in any return call. Review of the statement dated January 8, 2024, of Employee E11, a Registered Nurse, indicated as follows; I worked the Pine medication cart on the 7-3 shift on Sunday January 7, 2024. I did not go to the refrigerator to count the bottle of Ativan for [Resident R59]. I did not give [Resident R59] any Ativan during the 7-3 shift. The 3-11 Nurse did the narcotic count with me when she came onto her shift. I did not go to the refrigerator with her to count the Ativan. She went to the refrigerator herself and then came back and signed off on the narcotic count sheet that it was okay. I am unaware of any tampering that may have occurred with the Ativan bottle for [Resident R59]. On May 28, 2024, at 10:44 a.m., tried to interview Registered Nurse, Employee E11, over telephone, left message. On May 28, 2024, at 7:47 p.m. Registered Nurse, Employee E11, returned the call and stated that he I did not go to the refrigerator with the other nurse to count the Ativan, and confirmed the statement as explained above. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of employee statement dated January 8, 2024, of Employee E12, a Registered Nurse, indicated as follows: On Sunday January 7, 2024, I worked the 3-11 only. I counted with E11. I went to the refrigerator to check the Ativan by myself. It was full and still sealed. I signed the narcotic book with [Employee E11], indicating the count was correct. [Employee E10] came in for the 11-7 shift. We completed the narcotic count. I did not go with her to the refrigerator to check the Ativan. I believe that she went to count the Ativan in the refrigerator because she came back and signed the narcotic count log as being correct. She did not have any questions for me regarding the count. I had no idea there was any issue with the Ativan count or the Ativan bottle until I was questioned upon coming to work on January 8, 2024. Interview with the Director of Nursing on May 28, 2023, at 12:17 p.m., confirmed the findings, that the facility failed to implement procedures to promote accurate narcotic medication records . 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services.