

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Norriton Square Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Pine Street Norristown, PA 19401	
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	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38947</p> <p>Based on observations, staff interviews, and the review of facility documentation, it was determined that the pharmacy failed to timely respond to the facility inquiry of a possible error in the dispensing of a medication for 1 out of 4 residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy, Provider Pharmacy Requirements, with a date of January 2023 indicated that the provider pharmacy agrees to perform pharmaceutical services that include providing medications packaged in accordance with the nursing care center's need and equipment requirements and accurately dispensing prescriptions based on authorized prescriber orders.</p> <p>Review of the September 2024 physician orders indicated that Resident R1 had diagnosis that included cerebral infarction (a stroke); dysphasia (difficulty swallowing); aphasia (brain disorder that affects speaking and understanding language); heart disease, and hypertension (high blood pressure).</p> <p>Continued review of the September 2024 physician orders included a physician's order dated January 5, 2024, and monthly thereafter, for the medication Lisinopril (oral tablet). The order indicated that the resident was to be administered 1-40 milligram tablet by mouth, one time a day for the treatment of hypertension.</p> <p>Review of information reported to the State Survey Agency August 28, 2024 indicated that on August 27, 2024, Employee E3 (Licensed nurse) was in the process of administering the resident's Lisinopril to Resident R1 when licensed nurse noticed that the description of the medication on the medication card sent from the pharmacy department did not match the description of the medication that was actually packaged in that medication card.</p> <p>Continued review of the information submitted to the State Survey Agency indicated that the unidentified medication was not administered, and that after the Employee E3 and Employee E4 (unit manager) researched the medication that was in the medication card, both employees determined that the medication packaged in the medication card was 450 milligrams of Lithium (a mood stabilizer that is used to treat the manic episodes of bipolar disorder) instead of 40 milligrams of Lisinopril. The investigation concluded that the resident received 21 doses of Lithium over the past three weeks, that was not prescribed to him, instead of his prescribed medication, Lisinopril.</p> <p>(continued on next page)</p>		

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	<p>During an interview with Unit manager, Employee E4 on September 10, 2024 at 12:45 p.m. Employee E4 reported that she notified the facility's pharmacy representative regarding the medication card having the wrong medication in it, and the pharmacy representative informed her to send the medication back to the facility pharmacy on the above noted date, and that t he (pharmacy representative) would escalate the matter to the pharmacy manager.</p> <p>During an interview with Unit Manger, Employee E3 on September 10, 2024, at 2:00 p.m. Employee E3 confirmed the information in the interview that she provided in her statement regarding the discovery of the wrong medication packed in the medication card was accurate. Employee E3 was asked how the medication was verified to be Lithium, and she reported that both she and Employee E4 confirmed that the medication in the medication card was packaged with 450-milligram tablets of Lithium by researching the features of the medication imprinted on the Lithium tablet (e.g. numbers, letters, shape of the pill etc) on the internet.</p> <p>During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on September 10, 2024 at 3:30 p.m. it was discussed that although Employee E3 and Employee E4 researched the medication features on the internet and think that they determined through that search that the pills in the medication card were Lithium tablets, true verification of what the resident was administered for 21 days out of the month of August 2024 needs to be determined by the pharmacy. During the interview the DON confirmed that the pharmacy did not confirm the identity of the medication with the facility yet.</p> <p>The facility failed to ensure that pharmacy services accurately dispensed medication for Resident R1.</p> <p>28 Pa. Code 211.9 (a)(b) Pharmacy services</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services</p>		