

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Neshaminy Manor Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1660 Easton Road Warrington, PA 18976	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident interview, it was determined that the facility failed to ensure a call bell was accessible for one of 36 sampled residents. (Resident 129) Findings include: Clinical record review revealed that Resident 129 had diagnoses that included blindness in the right eye, fusion of the spine in the cervical region, and rheumatoid arthritis. The Minimum Data Set assessment dated [DATE], indicated that the resident was able to communicate her needs and was dependent on staff for assistance with activities of daily living. The care plan indicated the resident was at risk for falls and had vision impairment. Interventions included that the call bell should be kept within reach. On February 3, 2026, at 12:58 p.m., Resident 129 was observed in a wheelchair bedside her bed and her call bell was on the floor behind her. On February 5, 2026, at 11:46 a.m., the resident was observed in her wheelchair at the foot of the bed and the call bell was observed behind her wrapped around the side rail and out of reach. Both times, the resident stated she did not know where her call bell was, that her call bell could not be reached, and that she would like to have it. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for one of 36 sampled residents. (Resident 129) Findings include: Review of the policy entitled, Administration of Medication, last reviewed January 8, 2026, revealed staff were to obtain vital signs if necessary, and document physician indicated medication administration information on the Medication Administration Record (MAR). Clinical record review revealed that Resident 129 had diagnoses that included hypertension (high blood pressure). On October 25, 2024, the physician ordered staff to administer a blood pressure medicine (amlodipine besylate) one time a day. Staff were not to administer the medication if the resident's pulse (the number of times a heart beats in one minute) was less than 60 beats per minute. Resident 129's MAR for December 2025, and January and February 2026, revealed that staff administered the medication 31 times in December, 24 times in January, and two times in February with no documented evidence that the heart rate was assessed prior to medication administration per physician's order. In an interview on February 6, 2026, at 9:35 a.m., Assistant Director of Nursing 1 confirmed there was no documented evidence that Resident 129's pulse was taken prior to medication administration per physician's order as identified. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to assess residents with a diagnosis of post-traumatic stress disorder (PTSD) and develop and implement an individualized person-centered care plan to render trauma informed care for two of 36 sampled residents. (Residents 16 and 44) Findings include: Review of the facility policy entitled, Trauma Informed Care, last reviewed July 10, 2025, revealed that the social worker was to ask the resident or resident's responsible party (RP), at the time of admission, if there was any history of a traumatic experience and, if so, the social worker was to ask the resident or resident's RP if they would like to participate in a trauma related assessment to determine the level of trauma caused to ensure the care staff provided involved understanding, recognizing and responding to the effects of all types of trauma, and recognize the widespread impact and signs and symptoms of trauma in the resident and avoid re-traumatization. Clinical record review revealed that Resident 16 was admitted to the facility on [DATE], with diagnoses that included PTSD, anxiety, and depression. The Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was cognitively intact and had a diagnosis of PTSD. There was no documentation to support that the resident was asked if he wanted to participate in a trauma-related assessment to assess for symptoms or triggers related to the diagnosis of PTSD. There was no documentation to support that symptoms or triggers were assessed related to the diagnosis of PTSD. There were no specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. Clinical record review revealed that Resident 44 was admitted to the facility on [DATE], with diagnoses that included chronic PTSD, depression, and insomnia. Review of the MDS assessment dated [DATE], revealed that the resident was cognitively intact and had a diagnosis of PTSD. Review of facility documentation revealed that on March 30, 2020, a Psychiatry Nurse Practitioner's note indicated the resident was lonely and depressed, had been struggling with vivid nightmares that were scary, and had become tearful. On December 14, 2021, a physician noted the resident had PTSD. On April 19, 2023, a Psychiatry Nurse Practitioner's note indicated the resident was a veteran with a history of PTSD. Resident 44's care plan did not include any measure to address the resident's history of trauma or identify triggers. There was no documentation to support that symptoms or triggers were assessed related to the diagnosis of PTSD. There were no specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization on the care plan. In an interview on February 5, 2026, at 2:00 p.m., the Director of Social Work confirmed that Resident 16 and Resident 44 were not asked if they wanted to participate in a trauma related assessment. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		