STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395202	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broomall Manor	43 Church Lane Broomall, PA 19008

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records review and staff interview, it was determined that the facility failed to ensure medication was correctly administered to the resident and the physician's order regarding vital sign monitoring after a medication error incident was followed for one of two residents reviewed (Resident R1).Findings include: Clinical records review revealed Resident R1 was admitted to the facility on [DATE], with a diagnosis of small bowel obstruction and bladder cancer. A review of the progress notes dated December 19, 2025, at 5:46 a.m., revealed Medication error occurred this evening involving not prescribed medication Keppra (A medication used to treat seizures) PO (by mouth) and prescribed medication Lactulose (A medication used to treat constipation). Patient received 5 ml of Keppra PO instead of the ordered dose of 30 cc of Lactulose. Error identified during MAR (Medication Administration Record) review at 2130 (9:30 p.m.). A review of the facility's investigation, licensed nurse Employee E3's statement dated December 18, 2025, revealed Resident's evening medications were poured, including Lactulose. Lactulose was mistakenly poured into a medication cup in which Keppra had already been poured and emptied. Same cup with minimal Keppra mistakenly used by the nurse pouring Lactulose and was given to the resident. An interview was conducted with the Director of Nursing (DON) on December 16, 2025, at 1:00 p.m. The DON reported that Employee E3 accidentally poured Keppra instead of Lactulose into the medication cup. Employee E3 discarded the liquid Keppra, but with a minimal amount left, and decided to use the same medication cup and poured the ordered Lactulose and administered it to the resident. The DON confirmed that Resident R1's medication order was not correctly followed. A review of the progress notes dated December 19, 2025, at 5:46 a.m., revealed that after the medication error where Resident R1 was accidentally administered with 5 ml of Keppra, the physician was notified with orders received to monitor the resident's vital signs (Are measurements of the body's essential functions, which includes body temperature, pulse rate, respiratory rate, and blood pressure) every shift for two day. Clinical records revealed Resident R1's vitals were taken on the following days/times: December 19, 2025, at 5:55 a.m., blood pressure, respirations, pulse, temperature were taken; December 19, 2025, at 8:41 a.m., only blood pressure was taken; December 20, 2025, at 10:51 a.m., only blood pressure was taken; and December 21, 2025, at 8:50 a.m., only blood pressure was taken. Vital sign records revealed the following: Incomplete vital signs were taken on December 19, 2025, at the 7A-7P shift; Vital signs were not taken on December 19, 2025, on the 7P-7A shift. Incomplete vital signs on December 20, 2025, at the 7A-7P shift; No vital sign taken on December 20, 2025, on the 7P-7A shift. An interview with the Director of Nursing conducted on January 16, 2026, at 1:00 p.m., confirmed that the physician's order to monitor the resident's vital signs post medication error incident was not followed. The DON reported that the order to monitor the vital signs were put in the physician's order but was not properly transcribed into electronic medical records (EMR). The facility failed to ensure the physician's order to monitor Resident R1's vital signs was followed. 28 Pa. Code (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	211.12(d)(1)(3)(5) Nursing services 28 Pa Code 211.5(f) Clinical Records