

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER Naamans Creek Country Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1194 Naamans Creek Road Boothwyn, PA 19061	
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)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166</p> <p>Based on review of clinical records and staff interview it was determined that the facility failed to ensure that one resident out of 24 sampled was free of chemical restraints (Resident 63).</p> <p>Findings include:</p> <p>A review of Resident 63's clinical record revealed admission to the facility on [DATE], with diagnoses to include cerebral infraction (pathologic process that results in an area of necrotic tissue in the brain), cognitive communication deficit (difficulties in communication that arise from impairments in cognitive processes such as attention, memory, perception, and executive function), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>An admission Minimum Data Set assessment (a federally mandated standardized assessment completed periodically to plan resident care) dated January 24, 2025, indicated that the resident is moderately cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 12 (8-12 represents moderate cognitive impairment).</p> <p>A review of resident 63's clinical record revealed that the resident was prescribed Xanax (antianxiety, used to treat anxiety disorders and anxiety caused by depression) Oral Tablet 0.25 MG (milligrams) PRN (as needed) every 8 hours for 30 days, with a start date of February 14, 2025.</p> <p>Additional review of the resident's clinical record revealed an order to administer Nonpharmacological Intervention(s) used before PRN Pain Medication or before PRN antidepressant, antianxiety, antipsychotic or sedative/hypnotic medication Document by number: 1 Reposition for comfort 2 massage 3 involve in activity/alt. activity to divert 4 provide quiet setting with reduced stimuli as needed 5 relaxation technique 6 music 7 remove from area 8 direction/distraction with a start date of January 24, 2025.</p> <p>Review of Resident 63's medication administration record (MAR) for the month of March 2025, revealed the facility administered the Xanax to Resident 63 on March 5th 2025, March 12, 2025 and March 14, 2025.</p> <p>Further review of Resident 63's MAR for March 2025 revealed the facility did not attempt any Nonpharmacological Interventions prior to administering Xanax to Resident 63.</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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 63's progress notes failed to reveal any documentation of nonpharmacological Intervention being attempted prior to the administration of Xanax.</p> <p>An interview conducted with the Nursing Home Administrator (NHA) on May 2nd, 2025, at 11:25 a.m. confirmed the facility failed to attempt nonpharmacological Intervention prior to administering antianxiety medication to Resident 63.</p> <p>28 Pa. Code 211.8 (c.1)(1)(e) Use of Restraints.</p> <p>28 Pa. Code 211.5 (f) Medical records</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765</p> <p>Based on a review of the facility's policy, clinical records review, and staff interview, it was determined the facility failed to ensure physician's orders were followed for three of the 18 residents reviewed (Residents 13, 14, and 66).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Weighing of Residents, undated revealed that residents requiring daily weights due to clinical conditions warranting strict monitoring will be weighed in the same procedures as stated above. Documentation of the daily weight will be recorded in the electronic medical record (EMR). If the resident experiences a weight gain of three (3) pounds in a 24-hour period or a weight gain of greater than five (5) pounds in a week, the licensed nurse will notify the physician.</p> <p>Clinical records review revealed Resident 13 was admitted to the facility on [DATE], with a diagnosis of Congestive Heart Failure (CHF weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs).</p> <p>A review of Resident 13's physician's order dated April 2, 2025, revealed an order to weigh the resident one time a day for monitoring.</p> <p>Clinical records review revealed Resident 13's daily weight monitoring was not done on the following dates: April 4, 5, 8, 10, 11, 13, 14, 15, 19, 21, 22, and 28, 2025.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) on May 1, 2025, at 10:00 a.m. The ADON confirmed that Resident 13's daily weight monitoring was not done on the dates mentioned above. The ADON was unable to provide an explanation as to why Resident 13's weights were taken as ordered by the physician.</p> <p>An observation conducted on May 2, 2025, at 10:00 a.m., revealed Resident 14 was sitted in a wheelchair. Further observation revealed Resident 14's bilateral lower legs were swollen.</p> <p>Clinical records review revealed Resident 14 was admitted to the facility on [DATE], with a diagnosis of CHF.</p> <p>A review of Resident 14's physician's order dated April 10, 2025, revealed an order to weigh the resident one time for monitoring.</p> <p>Clinical records review revealed Resident 14's daily weight monitoring was not done on the following dates: April 13, 14, 15, 23, and 24, 2025. Further review revealed Resident 14's weight taken on April 22, 2025, was 130.4 pounds, Resdient refused his weight on April 25, 2025 and the weight taken on April 26, 2025, was 136.4, a six-pound weight gain in four days. The record review failed to reveal that the physician was notified of the six-pound weight gain in four days.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the physician's note dated April 30, 2025, revealed Resident 14 was seen in bed with an increased lower extremity edema. The physician ordered Lasix (A medication that treats fluid retention and swelling caused by CHF, liver disease, kidney disease, and other medical conditions) 40 mg for one dose.</p> <p>An interview was conducted with the ADON on May 1, 2025, at 10:00 a.m. The ADON confirmed that Resident 14's daily weight order was not done on the dates mentioned above. The ADON also confirmed that the physician was not notified of the six-pound weight gain on the four days between obtained weights identified on April 26, 2025.</p> <p>The facility failed to ensure Resident 13's and 14's daily weight monitoring orders were followed as ordered.</p> <p>Review of resident 66's diagnosis list includes Orthostatic Hypotension (significant drop in blood pressure due to standing up.)</p> <p>Review of Resident 66's physician orders dated April 1, 2025, revealed an order for Midodrine (used to treat low blood pressure) HCL 2.5 milligrams (MG), Give 1 tablet by mouth three times a day for orthostatic hypotension Hold for SBP (Systolic Blood Pressure) above 120mmHG.</p> <p>Review of Resident 66's medication administration record (MAR) for the month of April 2025 revealed that from April 1, 2025, until April 7, 2025, facility administered Midodrine to the resident 20 times without checking blood pressure for parameters. Further review revealed that from April 8, 2025, until April 26, 2025, resident was given Midodrine medication four times outside ordered parameter.</p> <p>An interview with the Interim Director of Nursing conducted on May 2, 2025, at 11:00 a.m., confirmed that parameters for Midodrine medication was not followed.</p> <p>The facility failed to ensure Resident 66's Midodrine medication order was followed</p> <p>28 Pa Code 211.10(c)Resident Care Policies Previously cited 5/17/24</p> <p>28 Pa Code 211.12(c)(d)(3) Nursing Services Previously cited 5/17/24</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>41765</p> <p>Based on review of facility's policy, clinical records review and staff interviews, it was determine that the facility failed to appropriately monitor the weights and timely address identified significant weight changes for three of 18 Residents reviewed (Resident 63, 66 and 175).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Weighing of Residents, undated, revealed that the facility must monitor the resident's weight to detect significant weight loss or gain to ensure that the resident maintains acceptable parameters of nutritional status. The same policy revealed that upon admission and readmission, the resident is weighed weekly for one month. An assigned licensed nurse or designee should review resident weights after they are entered or recorded. If the resident exhibits a change of five (5) pounds from the previous month's weight report and three (3) pounds from the previous weight report, the resident shall be reweighed within 24 hours and the re-weight shall be recorded. If the weight change falls into the significant category- 5% in one month or 10% in six months, the dietitian will complete an assessment to investigate the cause of the weight change. The charge nurse will notify the dietitian, the physician, and the family of the significant weight changes.</p> <p>Review of Resident 66's diagnosis includes Type 2 Diabetes (DM- failure of the body to effectively use insulin produced in the body, insulin regulates blood sure to pass from blood stream to cells) and Gastroesophageal reflux disease (Gerd- failure of the body to stop stomach acid from flowing back into the esophagus causing irritation to the lining of the esophagus.)</p> <p>A review of Resident 66's clinical records weight and vitals revealed, on March 29, 2025, Resident 66 weighed 192.4 and on April 16, 2025, the resident weighed 172.4 pounds a 10.40% weight loss in 18 days. Clinical record review revealed a re-weight was not completed until 2 days later revealing residents' weight was 172.4 Pounds.</p> <p>Clinical records review failed to reveal that the physician was notified of the significant weight loss and that an intervention was put in place.</p> <p>The facility failed to ensure physician was notified of Resident 66's significant weight loss and further intervention were put in place to prevent further weight loss</p> <p>An interview with the Interim Director of Nursing conducted on May 2, 2025, at 10:00 a.m., confirmed that the resident's physician was not notified of the significant weight loss and interventions were not put in place to prevent further weight loss.</p> <p>A review of Resident 175's diagnosis list includes Dementia (A term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), and dysphagia (Difficulty swallowing).</p> <p>A review of Resident 175's Weights and vitals, revealed a weight of 150.2 pounds on April 16, 2025, and 139.4 pounds on April 23, 2025, a 10.8 (7.19%) significant weight loss in seven days.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical records review revealed reweight was not done until two days after which revealed a weight of 140.2 on April 25, 2025, a 6.66% weight loss in a week.</p> <p>The clinical records review failed to reveal that the resident was assessed after identifying the significant weight loss. The records also failed to reveal that the physician was notified of the significant weight change and that an intervention was put in place to prevent further weight changes.</p> <p>An interview with the Dietitian, Employee E4 was conducted on May 1, 2025, at 1:00 p.m. Employee E4 reported that she/he was not notified of the resident's weight loss identified on April 23, 2025.</p> <p>An interview with the Interim Director of Nursing conducted on May 2, 2025, at 10:00 a.m., confirmed that the resident was not assessed when significant weight loss was identified and that the physician was not notified of the significant weight change.</p> <p>The facility failed to ensure Resident 175's significant weight loss was assessed and addressed in a timely manner.</p> <p>28 Pa Code 211.10(c)Resident Care Policies</p> <p>Previously cited 5/17/24</p> <p>28 Pa Code 211.12(c)(d)(3) Nursing Services</p> <p>Previously cited 5/17/24</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41765</p> <p>Based on clinical record review and staff interviews, it was determined that the pharmacy failed to ensure medication for wound care was available for one of the four residents reviewed (Resident 175).</p> <p>Findings include:</p> <p>A review of Resident 175's physician order dated April 29, 2025, revealed an order for Santyl (A topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin) ointment, apply nickel thick layer to the sacrum (The triangular bone just below the lumbar vertebrae) wound bed after cleansing with normal saline solution, cover with foam dressing once a day and as needed. May use Medihoney (A dressing that aids and support debridement and a moist wound healing environment in acute and chronic wounds and burns.) until Santyl arrives.</p> <p>An observation of the wound care treatment conducted on May 1, 2025, at 9:45 a.m., revealed that Medihoney treatment was used for the sacral wound instead of the Santyl.</p> <p>An interview with licensed nurse Employee E4 conducted on May 1, 2025, at 9:50 a.m., revealed that the facility was still using Medihoney instead of Santyl because the pharmacy had not delivered the medication yet.</p> <p>An interview conducted with the Assistant Director of Nursing on May 1, 2025, at 1:00 p.m., revealed that the medication order was sent to the pharmacy on April 29, 2025. A medication follow-up was made on April 30, 2025, and was informed that the medication would be delivered. On May 1, 2025, after another follow-up call, pharmacy representative [name of the pharmacist] reported that the medication delay was due to the absence of wound dimension documents. Records revealed order sent had dimension documents but was missed by the pharmacy.</p> <p>The pharmacy failed to ensure Santyl's medication for Resident 175's sacral wound was made available timely.</p> <p>28 Pa. Code 211.9(h) Pharmacy services.</p> <p>28 Pa Code 211.12(c)(d)(3) Nursing Services</p> <p>Previously cites 5/17/25</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968</p> <p>Based on observations, review of facility policies, and interviews with staff, it was determined that the facility failed to store food in accordance with professional standards for food service safety for two of two nursing units (First Floor and Second Floor nursing units).</p> <p>Findings include:</p> <p>Review of the facility policy, Dry Food Storage dated [DATE], revealed, dry food storage is necessary for foods that do not require refrigeration or freezing and requires proper guidelines. All food items must be dated, labeled and sealed. Rotate products to ensure that the oldest inventory is used first.</p> <p>Observation on [DATE], at 9:45 a.m. of the second-floor kitchen dry food storage area revealed expired used by dates for multiple loaves of bread and packages of buns. This included, 1 package of hot dog buns use by dated [DATE], 1 loaf of wheat bread use by dated [DATE], 1 loaf of raisin bread use by dated [DATE], 5 packages of hamburger buns use by dated [DATE], of which 2 packages revealed black and green spots on the buns, and 9 loaves of rye bread with no visible received or use by dates.</p> <p>Interview with Director of Dietary Services, Employee E3, on [DATE], at 9:45 a.m. confirmed that items were not properly labeled or dated, items were expired, and the 2 packages of hamburger buns had visible black and green spots on them.</p> <p>The facility failed to ensure that food was stored properly, labeled and dated according to professional standards.</p> <p>28 Pa Code 201.18(b)(1) Management</p>		