

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2025
NAME OF PROVIDER OR SUPPLIER Phoenix Center for Rehabilitation and Nursing,the		STREET ADDRESS, CITY, STATE, ZIP CODE 833 South Main Street Phoenixville, PA 19460	

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>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on a review of closed clinical records, facility policy review, and staff interview, it was determined that the facility failed to assure a Residents right to be free of chemical restraints for one of one Residents reviewed. (Resident 6).Findings include:Review of facility policy, titled Administering Medications revision date December 2012 revealed Medications must be administered in accordance with the orders, including any required time frame.Review of Resident 6's clinical record revealed there was a current physician's order for the resident to be receiving Tramadol HCl 50 mg. Give one tablet by mouth every 6 hours as needed for moderate to severe pain. Also a related order Pain Assessment/Pain Monitor (Able to communicate - Do you have pain? If Denies - Stop here. If Yes - Indicate Pain score 0-10, Offer a non-pharmacological intervention: 1. Repositioning/Turning, 2. Distraction, 3. Massage, 4. Hot/Cold Compress, 5. Emotional Support, 6. Quiet Environment, 7. Other, 8. Not ApplicableReview of Resident 6's Medication administration record revealed that Tramadol was administered 3 times in June outside of parameters for a pain scale of 0, with no non-pharmacological interventions noted.Interview conducted with the Director of Nursing, Employee E2, at 07/31/2025 12:16 PM, when asked why tramadol was administered a response of, they did not know, and a pain scale of zero out of 10 is not moderate to severe pain.The facility failed to follow a physician's order for tramadol and provide non-pharmacological interventions for Resident 6. PA Code 211.10(c) Resident Care Policies</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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**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 ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for five of ten residents reviewed for hospitalization (Resident 1, Resident 3, Resident 31, Resident 86 and Resident 88).</p> <p>Review of Resident 1's clinical record revealed a face sheet documenting the resident has medical diagnoses that include Acute Respiratory Failure with Hypoxia (insufficient oxygen in blood).</p> <p>Review of Resident 1's clinical record revealed that they were transferred and admitted to the hospital on [DATE], due to respiratory distress.</p> <p>Further review of Resident 1's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer.</p> <p>Review of Resident 3's clinical record revealed Resident 3 was discharged to the hospital on June 14, 2025.</p> <p>Further review of Resident 3's clinical record failed to reveal evidence that Resident 3's representative or Resident 3 were notified of the facility's bed hold policy upon discharge to the hospital.</p> <p>Review of Resident 31's clinical record revealed diagnoses that included Acute kidney injury. (Acute kidney injury happens when the kidneys suddenly can't filter waste products from the blood. When the kidneys can't filter wastes, harmful levels of wastes may build up. The blood's chemical makeup may get out of balance.).</p> <p>Review of Resident 31's clinical record revealed that they were transferred and admitted to the hospital on [DATE].</p> <p>Further review of Resident 31's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer.</p> <p>Interview with the Director of Nursing on July 31, 2025, at 11:00 a.m. confirmed that no bed hold policy information was given to Resident 3 or their representatives upon discharge to the hospital.</p> <p>Review of Resident 86's clinical record revealed Resident 86 was discharged to the hospital on June 17, 2025, and again on July 7, 2025.</p> <p>Further review of Resident 86's clinical record failed to reveal evidence that Resident 86 or Resident 86's representative was notified of the facility's bed hold policy upon discharge to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 88's clinical record revealed diagnoses that included gram-negative sepsis unspecified (severe or potentially life-threatening condition that occurs when harmful bacteria invade the bloodstream and cause an overwhelming immune response).</p> <p>Review of Resident 88's clinical record revealed that they were transferred and admitted to the hospital on [DATE].</p> <p>Further review of Resident 88's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer.</p> <p>Interview conducted with the Director of Nursing (DON) on July 31, 2025 at 10:54 a.m., when the above information was presented, the DON confirmed that the bed hold notifications were not provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>

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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. (continued on next page)

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined that the facility failed to properly follow physician orders for three of 19 residents reviewed and failed to timely address a skin issue for one of 19 residents reviewed(Resident 1, Resident 5, Resident 30 and Resident 35).Review of Resident 1's face sheet revealed medical diagnoses that include Acute Respiratory Failure with Hypoxia (insufficient oxygen in blood). Review of Resident 1's clinical records revealed physician orders for oxygen continuous at 2 liters via nasal cannula every shift for monitor.Review of resident 1's clinical records revealed physician orders to change oxygen tubing, mask and/or nasal cannula weekly on Wednesday 11p.m. to 7 a.m. shift, date tubing and H2O bottle, wash filter, may change sooner as needed, every night shift every Wednesday for hygiene. Review of Resident 1's July 2025 Medication Administration Report (MAR)documents the tubing was last changed on July 30, 2025. Observations made of the tubing on Tuesday July 29, 2025, Thursday July 31, 2025, and Friday August 1, 2025, revealed the last documented date on the tubing was July 24, 2025. Observations made of oxygen tubing along with the Director of Nursing (DON) on August 1, 2025, at 10:45 a. m., confirmed Resident 1's oxygen tubing was documented for July 24, 2025.Review of Resident 5's face sheet revealed medical diagnoses that include Multiple Sclerosis (neurological disorder that affects central nervous system), Dysphagia Oropharyngeal Phase (difficulty swallowing while moving food from mouth into throat), other Abnormalities of Gait and Mobility (condition that affects walking and movement), and Need for Assistance with Personal Care.Review of Resident 5's clinical records revealed physician order dated February 5, 2025, for regular diet, mechanical soft texture, nectar thickened fluids consistency.Review of Resident 5's clinical records revealed physician order dated July 3, 2025, for staff to feed resident. Observations made on July 30, 2025, at 12:50 p.m., during lunch service showed Resident 5 feeding self with fingers. Staff did not assist the resident as per physician orders.Resident 5's lunch consisted of mechanical soft texture chicken alfredo and broccoli and Resident 5 was observed eating the meal with his/her fingers.Observations made on July 31, 2025, at 12:26 p.m., during lunch service showed Resident 5 feeding self with fingers. Staff did not assist the resident as per physician orders.Resident 5's Lunch consisted of mechanical soft texture candied sweet potatoes, cabbage and ham.Interview with Nursing Home Administrator (NHA) and DON on August 1, 2025, at 1:30 p.m., when the above was presented, the DON confirmed the physician orders for staff to feed resident were not followed. Review of Resident 30's face sheet revealed medical diagnoses that include Stage 2 Chronic Kidney Disease (mild to moderate decline in kidney function).Review of Resident 30's clinical records revealed a physician order dated May 31, 2025, for fluid restriction 2000 ml, nursing (7-3) = 360 cc, (3-11) =360 cc, (11-7) =200cc. Culinary breakfast 360cc, lunch 360 cc, dinner 360cc every shift for monitor.Review of Resident 30's 30-day fluid consumption task form revealed the resident's fluids were not being properly monitored by nursing staff.Further review of Resident 30's 30-day fluid consumption task form revealed no documentation from dietary staff noting the resident's fluid consumption. Review of Resident 30's July 2025 MAR revealed on July 10, 2025; nursing staff documented the resident obtained and consumed 420cc of fluids which was 180cc over the prescribed amount. Further review of Resident 30's July 2025 MAR revealed for 16 out of 30 days the resident received and consumed more than the physician ordered amount 200cc for 11 p.m. to 7 a. m. shift.Review of Resident 30's June 2025 MAR revealed the resident's fluid restrictions were not being followed by nursing staff.Interview with the NHA and DON on August 1, 2025, at 1:30 p.m., when the above was presented, the DON confirmed the physician orders for fluid restrictions were not being followed by either nursing staff or dietary staff.Review of Resident 35's diagnosis list revealed diagnoses including Alzheimer's Disease (irreversible, progressive degenerative disease of the brain, resulting in loss of reality, contact and functioning ability).Review of Resident 35's skin assessment dated [DATE], revealed little bumps are observed on resident hands, back and chest. Resident was observed scratching them continuously.Review of complaint allegations revealed that a groin rash as well as a body rash was reported to the facility in June 2025.Review of Resident 35's physician orders revealed an order dated July 28, 2025, for Nystatin External Cream (fungal cream) to be applied.Further review of Resident 35's clinical record failed to reveal evidence that the skin assessment and body rash were addressed from June 28, 2025, through July 28, 2025. Interview with the Director of Nursing on July 31, 2025, at 11:00 a.m. confirmed the above information. 28 Pa Code 211.12(d)(1)(2)(5) Nursing Services Previously cited 8/22/2024 11/21/2024 12/31/2024</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on clinical record review, and staff interview, it was determined the facility failed to provide a hazard free environment for one of eight residents reviewed (Resident 6). Findings include: Review of facility policy, titled smoking policy - residents revision date 07/2017 revealed A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. Review of Resident 6's clinical record revealed the most recent smoking assessment was dated June 09, 2024. Upon interview with Director of Nursing on August 01, 2025 at 09:34 am it was revealed that the last smoking assessment was June 09, 2024. The facility failed to provide a hazard free environment for Resident 6. PA Code 211.10(c) Resident Care Policies</p>