

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Manatawny Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Old Schuylkill Road Pottstown, PA 19465	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765</p> <p>Based on observations and staff interviews, it was determined that the facility failed to provide a safe and homelike environment for one of the four units observed (Milestone Unit).</p> <p>Findings include:</p> <p>An observation on the Milestone unit conducted on January 28, 2025, revealed the following: At 11:51 a.m., room [ROOM NUMBER]'s wall by the window was observed with two holes measuring 3.0 x 5.0 inches and the other hole measuring 2.0 x 5.0 inches; 11:58 a.m., room [ROOM NUMBER]'s wall by the window was observed with one hole measuring 5.0 x 7.0 inches; and at 12:01 p.m., room [ROOM NUMBER]'s wall by the window was observed with two holes one measuring 2.0 x 11 inches and the other was 2.0 x 2.0 inches.</p> <p>An observation conducted on January 31, 2025, at 11:20 a.m., in the presence of Employee E3 revealed that the above observations on Milestone unit rooms [ROOM NUMBER] were still present.</p> <p>An interview conducted with Employee E3 on January 31, 2025, at 11:30 a.m. revealed that he/she was not aware nor informed of the holes in the walls in rooms [ROOM NUMBER].</p> <p>The above findings were discussed with the Nursing Home Administrator on January 31, 2025, at 1:00 p.m.</p> <p>The facility failed to ensure a safe and homelike environment in the Milestone Unit.</p> <p>28Pa Code 201.14(a) Responsibility of licensee.</p> <p>28Pa Code 201.18(b)(e)(1)Management</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>22502</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to develop a comprehensive care plan for two of 25 residents reviewed (Residents 22 and 108).</p> <p>Findings include:</p> <p>Review of Resident 22's CRNP's (certified registered nurse practitioner) progress note of January 10, 2025, revealed that the resident was seen and examined for complaints of urinary retention. New order to insert foley catheter (sterile tube inserted into the bladder to drain urine) if needing straight catheterization (intermittent emptying of urine from the bladder using a small tube) for all three shifts. Additional progress note of January 10, 2025, revealed that a foley catheter was inserted for urinary retention.</p> <p>Review of CRNP progress note of January 21, 2025, revealed an order to remove the resident's catheter and complete a bladder scan (procedure used to assess the amount of urine retained within the bladder) every shift for three days related to a voiding trial. Review of progress note of January 22, 2025, revealed resident continues to retain urine per bladder scan and foley catheter placed as ordered.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on January 31, 2025, at 1:13 p.m. confirmed that a care plan had not been developed for urinary retention or a foley catheter.</p> <p>Review of Resident 108's CRNP progress notes dated January 30, 2025 revealed Patient seen and examined today to review labs drawn yesterday and to follow up on CHF [congestive heart failure - excessive body/lung fluid caused by a weakened heart muscle].</p> <p>Further review of Resident 108's CRNP progress notes dated January 30, 2025 revealed [resident] has been taking Furosemide [Lasix - diuretic used to reduce fluid] 20 mg [milligrams] daily x 3 days. Given only mild decrease, will increase Furosemide. [Resident] continues with edema to right elbow.</p> <p>Review of Resident 108's care plan failed to reveal evidence of a care plan for the increase in Lasix and failed to reveal evidence of a care plan for right elbow edema.</p> <p>Interview with Director of Nursing on January 31, 2025 at 9:45 a.m. confirmed that no care plan existed for Resident 108's right elbow edema and also confirmed there was no care plan for Resident 108's increase in Lasix.</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 2/15/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p> <p>Previously cited 2/15/24</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>35913</p> <p>Based upon clinical record review, it was determined the facility failed to revise a care plan to reflect changes in nutrition for a resident with weight loss for one of 25 residents reviewed (Resident 84).</p> <p>Findings include:</p> <p>Review of Resident 84's clinical record revealed between December 14, 2024 and January 6, 2025 Resident 84 had a 5.89 % weight loss.</p> <p>Further review of the clinical record revealed weight warning note from the dietitian dated January 6, 2025 identifying the weight loss and suggesting adding pudding to lunch and dinner and to also add desert for additional calories.</p> <p>Review of Resident 84's care plan failed to reveal that the care plan was revised to include the changes in nutrition from the dietitian.</p> <p>Interview with Director of Nursing on January 31, 2025 at 9:45 a.m. confirmed that the care plan was not revised to include changes from the dietitian.</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 4/30/24, 3/8/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p> <p>Previously cited 6/11/24, 4/30/24, 3/8/24</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>22502</p> <p>Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that necessary treatments were provided for two of five residents with a pressure ulcer (Residents 71 and 177).</p> <p>Findings include:</p> <p>Review of Resident 71's wound consult of January 27, 2025, revealed resident presented with a stage 3 pressure ulcer (full thickness tissue loss) of the left heel. The consult indicated a new order recommendation to cleanse with wound cleanser, apply betadine (antiseptic solution used to disinfect open wounds), and leave open to air daily and prn (as needed). Review of the physician's orders and TAR (treatment administration record) revealed that the order was not implemented.</p> <p>Interview with the Director of Nursing (DON) on January 31, 2025, at 11:17 a.m. confirmed that the treatment order was changed during wound rounds, but the order was not put into place.</p> <p>Review of Resident 177's wound consult of January 20, 2025, revealed resident presented with a stage 2 pressure ulcer (shallow wound with partial thickness skin loss) of the sacrum (large, triangular bone at the base of the spine). The consult indicated a new order recommendation to clean with wound cleanser, apply house barrier cream, and leave open to air daily and prn. Review of the physician's orders and TAR revealed that the order was not implemented.</p> <p>Interview with the DON and Nursing Home Administrator on January 31, 2025, at 1:05 p.m. confirmed that the order to change the treatment was not implemented.</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 2/15/24</p> <p>28. Pa. Code 211.12(d)(1)(3)(5) Nursing services</p> <p>Previously cited 2/15/24</p>		