

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 03/19/2026
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, and staff interview, it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of three nursing units (Unit A Medication Cart). Findings include: During an observation conducted on A Wing on March 18, 2026, at 8:33 a.m., a medication cart assigned to a licensed nurse (Employee E8) was observed unattended with the computer screen open, displaying residents' personally identifiable information (PII). Employee E8 was not present in the hallway or in the immediate vicinity of the medication cart, creating the potential for unauthorized access to resident information. During a second observation conducted on A Wing on March 19, 2026, at 8:45 a.m., a medication cart assigned to a licensed nurse (Employee E9) was again observed unattended with the computer screen open, displaying residents' personally identifiable information. Employee E9 was not present in the hallway or near the medication cart, creating the potential for unauthorized access. During an interview on March 19, 2026, at approximately 2:10 p.m., the Nursing Home Administrator (NHA) confirmed that the facility did not ensure the confidentiality of residents' medical information in accordance with regulatory requirements. 28 Pa Code 211.5(b) Medical records</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, and staff interviews it was determined that the facility failed to properly secure medications in two of two medication carts located in nursing unit A. Findings include: Review of the facility policy Administering Medication last revised April 2020 states During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medication are kept on top of the cart. During an observation on Nursing Unit A on March 16, 2026, at 9:50 a.m., a medication cart was observed unlocked in the hallway outside a resident room with no nursing staff present in the immediate vicinity. During an interview on March 16, 2026, at 9:52 a.m., a licensed nurse (Employee E8) stated that the medication cart should have been locked. Employee E8 then secured the medication cart before responding to a resident call bell. During an observation on Nursing Unit A on March 17, 2026, at 8:37 a.m., a medication cart was observed unlocked in the hallway outside Resident 29's room. Crushed medication in a plastic cup was observed on top of the cart. The assigned licensed nurse (Employee E9) was at the opposite end of the hallway speaking with other staff. During an interview on March 17, 2026, at 8:39 a.m., Employee E9 confirmed that the medication cart should have been locked and that medications should not be left unattended on top of the cart. During an observation on Nursing Unit A on March 18, 2026, at 8:19 a.m., a medication cart was observed unlocked in the hallway between Resident 5's and Resident 90's rooms. An unidentified blister pack was observed beneath two pieces of paper on top of the cart. The assigned licensed nurse (Employee E9) was at the end of the hallway speaking with other staff. During an interview on March 19, 2026, at 1:20 p.m., the Director of Nursing (DON) confirmed that nursing staff are required to lock medication carts when unattended and are not permitted to leave medications unsecured on top of medication carts. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based upon policy review and observation, it was determined that the facility failed to ensure infection control practices related to transmission-based precautions were implemented on one of four nursing units. Findings include: Centers for Disease Control (CDC) Guidance on Transmission-Based Precautions dated April 3, 2024, recommend Contact Precautions for patients with known or suspected infections that represent an increased risk of for contact transmission (the spread of infection through direct or indirect contact with contaminated environments). The recommendations advise wearing personal protective equipment (PPE) appropriately, including gloves and gown for all interactions that may involve direct contact with the resident or the resident's environment. The CDC recommends Droplet Precautions for patients known or suspected to be infected with pathogens (disease causing germs) transmitted by respiratory droplets, that are generated by a patient who is coughing, sneezing, or talking. The facility's Infection Prevention and Control Program policy (revised in October 2018) indicated that Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures .and implementing appropriate isolation precautions when necessary. Observation of Unit C on March 18, 2026, between approximately 1:00PM and 1:15PM revealed a sign on the door to the entrance of the unit instructing staff and visitors to wear a mask due to a respiratory outbreak on the unit. Further observation revealed staff not wearing masks, entering resident rooms to deliver clean laundry. Additional observation revealed the same staff entering a room with a Contact Precaution sign (Resident 2's room), without protective equipment. These same staff entered rooms that were not on any precautions and subsequently entered rooms with droplet precautions in place (Residents 26's, Resident 52's, and Resident 116's rooms) without any protective equipment. Personal protective equipment was available in bins outside every unit where there were transmission precautions in place. Interview with the DON, who is the current Infection Prevention Nurse and E3 on March 19, 2026, at approximately 9:15AM, revealed that the outbreak of respiratory virus on Unit C was confirmed on March 11, 2026, and whole house education including hand-washing audits, the use of personal protective equipment and infection prevention was performed on March 12, 2026. Interview with the DON and E3 on March 19, 2026, at approximately 1:30 confirmed that all staff should be wearing masks when on a unit where there is an outbreak and following posted transmission-based precaution signs. 28 Pa Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to provide dignity for the use of an indwelling urinary catheter for one of 32 residents reviewed (Resident 80). Findings include: Observations of Resident 80's room on March 17, 2026, at 11:34a.m., 12:00 p.m., 1:16p.m., and 2:08 p.m. revealed Resident 80 in bed, with catheter bag hooked to the side of his bed visible from the door with no privacy bag cover. Interview with Employee 5 on March 17, 2026, at 2:08 p.m. confirmed that Resident 80 did not have a privacy cover on catheter bag. Interview with Nursing Home Administrator on March 19,2026 at 11:15 a.m. confirmed the above findings. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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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>Based on clinical records review, and staff interviews, it was determined that the facility failed to implement the comprehensive care plan intervention to prevent alteration in nutrition and/or hydration for one of eight residents reviewed (Resident 89). Findings include: Review of Resident 89's medical diagnoses revealed diagnoses that include Parkinson's Disease (a disorder that affects movement caused by degeneration of nerve cells in the brain), Congestive Heart Failure, (CHF), (a condition when the heart cannot pump blood effectively), Chronic Obstructive Pulmonary Disease, (COPD), (a progressive lung disease that makes it difficult to breathe), and Gastroesophageal Reflux Disease, (GERD), (a condition where stomach acid flows back into the esophagus). Review of Resident 89's records revealed a care plan dated March 9, 2026, documenting the resident is at nutritional risk related to Parkinson's CHF, COPD, GERD, and BMI (body mass index) of 35.9 indicating class II obesity. Interventions included monitor /record/report to MD signs/symptoms of malnutrition: including significant weight loss of 3 pounds (lbs) in a week, greater than 5% in one month, greater than 7.5% in three months, and greater than 10% in six months. Review of Resident 89's 30-day weights, revealed an admission weight of 171.4 on March 5, 2026, 172 on March 9, 2026, and 165 on March 16, 2026 indicating a 7 lb weight loss in 7 days. Review of Resident 89's progress notes revealed no documentation of the physician being notified regarding the resident's weight loss. During an interview with Dietician Employee E6 on March 18, 2026, at 10:53 a.m., Employee E6 stated dietary staff only assess residents who trigger for a 5% or greater weight loss or if requested by nursing staff. Employee E6 stated he/she was not aware of Resident 89's 7 lb weight loss because it was only -4.07% and did not reach the -5% required to trigger a red flag. Employee E6 confirmed creating the interventions but denied knowledge of the intervention requiring notification to the physician of a 3lb weight loss in a week. Employee E6 stated the intervention was generic and confirmed it was not resident centered. Employee E6 confirmed the physician was not notified of the weight loss. 28 Pa. Code 211.5(f) Clinical records 28 Pa Code 211.11(d) Resident care plan 3/26/18, 8/4/21, 9/29/21 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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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>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>Based on review of clinical records, medication regimen review, and staff interview, it was determined the facility failed to ensure the physician's medication order was followed for one of the eight residents reviewed (Resident 86). Findings include: Review of facility policy titled Administering Medications, last revised April 2020, states Medications are administered in accordance with prescriber orders, including any required time frame. Review of Resident 86's physician order dated November 29, 2024, revealed an order for midodrine hcl oral tablet 5 milligrams (MG) (raises blood pressure), Give 5 mg by mouth two times a day for orthostatic hypotension (a condition characterized by a significant drop in blood pressure upon standing) BP HOLD for systolic blood pressure (top number) greater than 130. Review of the January's 2026 Medication Administration Record (MAR) revealed that for the month of January 2026, Resident 86 received midodrine 5 mg ten times outside of the written parameters. The dates are as follows Date Time SBP 132 January 08, 2026, 5:00 p.m. 132 January 13, 2026, 5:00 p.m. 134 January 14, 2026, 9:00 a.m. 134 January 14, 2026, 5:00 p.m. 134 January 16, 2026, 8:00 a.m. 133 January 16, 2026, 5:00 p.m. 138 January 25, 2026, 5:00 p.m. 131 January 26, 2026, 8:00 a.m. 138 January 29, 2026, 8:00 a.m. 131 Review of medication regimen review dated February 6, 2026, states under recommendation 1 Resident 86 is ordered midodrine administered outside hold parameters on several dates in January. Interview conducted with Resident 86 on March 18, 2026, at 8:45 a.m. reported that she was not aware of receiving their medication outside of the prescribed hold parameters. Interview with the Nursing Home Administrator (NHA) conducted on March 19, 2026, at 2:10 p.m. confirmed that staff administered midodrine 5 mg outside of the prescribed hold parameters. 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure proper monitoring of fluid restrictions for two of eight residents reviewed for nutrition/hydration needs (Resident 3 and Resident 9). Findings include: Review of facility policy, titled Weight Assessment and Interventions last revised September 2008 states the physician, and the multidisciplinary team will identify medical conditions and medications that may cause fluid and nutrient loss and/or inadequate availability of food or fluids. Review of Resident 3's clinical record revealed diagnoses that included chronic diastolic heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 3's physician orders revealed an order for 1500 ml (milliliters) fluid restriction in 24-hour period, with an original start date of February 12, 2026. Per the order 840 ml of fluid was to be provided with meals and 660 ml to be provided by nursing staff. Review of Resident 3's February and March 2026 Medication Administration Report (MAR) and 30-day task documentation for amount of fluid intake obtained from nursing staff for the past 30 days, in addition to the amount of fluids provided with meals, revealed that the combined fluid intake exceeded the restriction of 1500 ml 30 out of 30 days. Review of Resident 9's clinical record revealed diagnoses that included chronic kidney disease stage 3 (kidneys filtering blood at about half the normal capacity), and chronic diastolic congestive heart failure (heart failure in which the heart cannot fill properly). Review of Resident 9's physician orders revealed an order for 2000 ml fluid restriction in 24-hour period, with an original order date of February 4, 2026. Per the order 1080 ml should be provided with meals and 920 ml obtained from nursing staff. Further review of the physician orders revealed an order for Medication Pass (a procedure used to administer medications safely and efficiently) two times a day 60 cc (cubic centimeter) BID (twice a day). Review of Resident 9's February and March 2026 MARs and 30-day task documentation for amount of fluid obtained from nursing staff in addition to the amount of fluids provided with meals, revealed that the combined fluid intake exceeded the restriction of 2000 ml for thirteen out of thirty days. Further review of Resident 9's February and March MARs revealed the resident's 120 cc daily medication pass was exceeded on nineteen out of thirty days. During an interview with Dietician Employee E6 on March 18, 2026, at 10:53 a.m., revealed dietary staff are not involved in ordering or monitoring fluid restrictions. During an additional interview with Employee E6 and Culinary Director Employee E7, Employee E7 provided a standard fluid restriction breakdown for nursing and culinary departments according to restriction amount. Employee E7 stated the culinary department provides fluids with meals per the guidelines but no documentation is made in resident records. During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on March 19, 2026, at 11:26 AM, the DON stated that nurses were documenting fluid amounts in the MAR while nurse aides were documenting the task forms. The DON stated going forward only the nurses would document fluid intake amounts. The DON confirmed it was hard to determine the exact amount of fluids the resident received. 201.18(b)(1) Management 211.10(c) Resident care policies 211.12(d)(1)(2)(5) Nursing services</p>		