

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER Pottstown Skilled Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 724 North Charlotte St Pottstown, PA 19464	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for four of 28 sampled residents. (Residents 84, 97, 112, 119) Findings include: Review of the facility policy entitled, Medication Administration, last reviewed on May 11, 2026, revealed that staff was to practice hand hygiene prior to administering medication and was to remove medication from source, taking care not to touch medication with bare hands. Review of the facility policy entitled, Enhanced Barrier Precautions (EBP), last reviewed on May 11, 2026, revealed that staff was to wear a gown and gloves during high contact resident care activities, such as bathing and dressing residents with wounds, to prevent infections. Clinical record review revealed that Resident 84 had diagnoses that included a history of strokes, dementia, and diabetes. A Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 84 required assistance with activities of daily living and had cognitive impairment. Observation on April 27, 2026, at 8:21 a.m. revealed that Licensed Practical Nurse 1 (LPN 1) was observed pouring the medications from blister packs and bottles into her bare hand without the use of gloves or hand sanitizer and then placed them into cups before she administered them to Resident 84. Clinical record review revealed that Resident 112 had diagnoses that included a history of strokes and dementia. An MDS assessment dated [DATE], revealed that Resident 112 required assistance with activities of daily living and had a cognitive impairment. Observation on April 27, 2026, at 8:30 a.m. revealed that LPN 1 poured the medications from blister packs and bottles into her open hand without the use of gloves or hand sanitizer and then placed them into cups before she administered them to Resident 112. In an interview on May 28, 2026, at 2:12 p.m., the Director of Nursing stated that medications should be emptied directly from blister packs or bottles into a cup without being handled by ungloved hands before administration. Clinical record review revealed that Resident 97 was admitted to the facility on [DATE], with diagnoses that included cancer, peripheral vascular disease (reduction of blood flow to the arms or legs due to narrowing or blocked arteries), varicose veins of right lower extremity with ulcer of calf, thrombocytopenia (low platelet count in blood which can cause bleeding problems) and need for assistance with personal care. Review of the MDS assessment dated [DATE], revealed that the resident had one venous wound. Clinical record review revealed that Resident 97 was on EBP. On May (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	22, 2026, a skin evaluation revealed Resident 97 had a venous ulcer of the left shin. Review of the care plan revealed that Resident 97 was on EBP related to a chronic wound and interventions were for direct care staff to utilize gowns and gloves for all personal care. Observation of the resident's room on May 27, 2026, at 10:25 a.m., revealed that there was a sign that indicated that EBP were to be implemented for Resident 97. On May 27, 2026, at 10:35 a.m., a nurse aide (NA 2) was observed dressing Resident 97 in bed without wearing a gown. In an interview on May 28, 2026, at 2:25 p.m., the Administrator confirmed that NA 2 should have worn a gown while dressing Resident 97 in bed. Clinical record review revealed that Resident 119 was admitted to the facility on [DATE], with diagnoses that included diabetes, pressure ulcer of the left buttock, and cellulitis of left lower limb (bacterial infection on the left leg). Review of the MDS assessment dated [DATE], revealed that the resident had a pressure ulcer. Review of the care plan revealed that Resident 119 had a stage four pressure ulcer on the left buttock related to limited mobility and incontinence. A physician's order dated May 19, 2026, directed staff to implement enhanced barrier precautions every shift for infection control. Observation on May 28, 2026, at 10:35 a.m., revealed a sign outside of Resident 119's room that directed staff to follow enhanced barrier precautions by wearing a gown and gloves during high contact resident care activities such as bathing residents with a wound to prevent infection. During the same observation period, a nurse aide (NA 1) was observed bathing Resident 119 in bed without wearing a gown. In an interview on May 28, 2026, at 12:45 p.m., the Regional Resource Nurse Manager confirmed that NA 1 should have worn a gown while bathing Resident 119 in bed. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on clinical record review and staff interview, it was determined that the facility failed to electronically transmit encoded Minimum Data Set (MDS) data to the Centers for Medicare and Medicaid Services (CMS) within 14 days of completion of the resident assessment for one of 26 sampled residents. (Resident 31)Findings include: Clinical record review revealed that Resident 31's Discharge MDS assessment was completed on December 3, 2025, but had not been exported as of May 28, 2026. In an interview on May 29, 2026, at 10:10 a.m., the Regional Resource Nurse Manager confirmed that the MDS assessment had not been exported. 28 Pa. Code 211.5(d) Medical records.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide care and services to maintain activities of daily living (eating and hygiene) for two of 28 sampled residents. (Residents 84 and 123) Findings include: Clinical record review revealed that Resident 84 had diagnoses that included a history of strokes, dementia, and diabetes. A Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 84 required maximum assistance with hygiene and self-care and had a cognitive impairment. Review of the care plan revealed that staff were to assist the resident with hygiene and self-care. On December 14, 2024, the physician ordered for staff to apply a left hand roll splint in the evening and remove it in the morning everyday. On May 27, 2026, at 8:21 a.m., the resident was observed in his room. The nails on both hands were long and dirty. The nails on his contracted left hand were digging into his palm. In an interview at that time, Resident 84 stated that he would like his nails trimmed and cleaned, and that he would not refuse nail care on his bath day. The resident also stated that the nurses put the left hand roll splint on his hand before bed and remove it in the mornings with breakfast. Documentation revealed that Resident 84 was last bathed by staff on May 26, 2026, and he had not refused care. On May 28, 2026, at 10:02 a.m., the resident was observed in his bed. His nails remained long and digging into his palm, with dirt beneath them, and an odor was detected from the resident's contracted left palm. There were no documented refusals of care. Clinical record review revealed that Resident 123 had diagnoses that included Alzheimer's Disease, dementia, and malnutrition. Review of the MDS assessment dated [DATE], revealed the resident had cognitive impairments and was dependent on staff for assistance with activities of daily living (ADL), including personal hygiene, dressing, and eating. Occupational Therapy assessments dated January 29, 2026, and April 18, 2026, directed staff to supervise Resident 123 and provide touch cueing while eating. A care plan intervention, dated May 1, 2026, directed staff to provide cueing and assistance with eating. Observation on May 26, 2026, at 12:10 p.m., revealed Resident 123 sitting alone at a table in the dining room attempting to feed herself with her fingers and open a sealed juice cup with a fork. Resident 123 then motioned to staff to get their attention and staff did not respond. At 12:48 p.m., staff were observed removing Resident 123's meal tray that contained the remaining food items. Staff did not offer Resident 123 assistance or cueing during the observed meal period. In an interview on May 28, 2026, at 2:12 p.m., the Director of Nursing confirmed that nail care was to be done on shower days, and staff were to assist residents with eating as needed to maintain activities of daily living. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for one of 26 sampled residents. (Resident 119) Findings include: Clinical record review revealed that Resident 119 had diagnoses that included diabetes, high blood pressure, and cellulitis of left lower limb (bacterial infection on the left leg). A physician's order dated May 14, 2026, directed staff to apply heel boots (devices to protect the skin of the feet) while in bed and check for skin breakdown throughout the day. Review of the care plan revealed that the resident was at risk for skin breakdown. Multiple observations on May 26 through 28, 2026, between 9:46 a.m., and 1:10 p.m., revealed Resident 119 in bed and the heel boots were not applied. In an interview on May 29, 2026, at 10:10 a.m., the Regional Resource Nurse Manager confirmed that staff did not apply the heel boots as ordered by the physician. 28. Pa Code 211.12(d)(1)(5) Nursing services.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide ongoing assessment and monitoring for one of 26 sampled residents receiving dialysis (process of removing excess toxins and water from the blood). (Resident 11)Findings include: A review of the facility policy entitled, Dialysis: Hemodialysis- Communication and Documentation, last reviewed May 11, 2026, revealed that staff were to complete the pre-dialysis portion of the Hemodialysis Communication Record that provided information regarding the resident's ongoing status to send with the resident to dialysis. Clinical record review revealed that Resident 11 had diagnoses that included end-stage renal (kidney) disease and dependence on renal dialysis and had a physician's order dated April 27, 2026, for the facility to provide dialysis three days per week. There was a lack of evidence to support that the pre-dialysis portion of the resident's dialysis communication forms were completed and that the resident was assessed before dialysis on 10 of 13 occasions from April 27, 2026, through May 25, 2026. In an interview on May 29, 2026, at 10:10 a.m., the Regional Resource Nurse Manager confirmed that communication forms were to be completed before dialysis to assess residents and that the forms were not completed. 28 Pa. Code 211.12(1)(3)(5) Nursing services.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) or legal representative of the reason for discharge, in writing, upon discharge from the facility for eight of eight sampled residents who were transferred out of the facility. (Residents 3, 7, 10, 12, 13, 83, 97, and 102) Findings include: Clinical record review revealed that Resident 3 was transferred to the hospital on February 13, 2026, and March 12, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 7 was transferred to the hospital on May 23, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 10 was transferred to the hospital on April 27, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 12 was transferred to the hospital on December 11, 2025, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 13 was transferred to the hospital on March 10, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 83 was transferred to the hospital on March 24, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 97 was transferred to the hospital on February 10, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 102 was transferred to the hospital on January 2 and 20, 2026, after changes in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. 28 Pa. Code 201.14(a) Responsibility of licensee.		