

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Towne Manor East		STREET ADDRESS, CITY, STATE, ZIP CODE 2004 Old Arch Road Norristown, PA 19401	

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 - Some</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** 43277</p> <p>Based on observations, and staff and resident interviews it was determined that the facility failed to maintain a clean, comfortable, and home-like environment for one of two nursing units observed (room [ROOM NUMBER]-B).</p> <p>Findings Include:</p> <p>Observations on October 29, 2024, at 10:28 a.m., revealed in the closet for Resident R15, room [ROOM NUMBER]-B, clothes were thrown in a messy pile in the closet. Observations revealed the rod in the closet had fallen, so staff were unable to hang the resident's clothes as intended.</p> <p>Interview on October 29, 2024, at 10:30 a.m. with alert and oriented Resident's R17 and R69 revealed the closet rod had been broken for a while.</p> <p>Observations on October 29, 2024, at 10:35 a.m. with the Director of Nursing, Employee E2, confirmed the closet rod in room [ROOM NUMBER]-B was broken and the resident's clothes were thrown in a pile.</p> <p>201.14 (a) Responsibility of licensee.</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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that a resident's transfer to the hospital was necessary and document the basis for the transfer in the resident's medical record for one of four residents reviewed related to transfers (Resident R55).</p> <p>Findings include:</p> <p>Review of Resident R55's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 9, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) and encephalopathy (brain damage). Continued review revealed that the resident was moderately cognitively impaired.</p> <p>Review of Resident R55's care plan, dated initiated September 8, 2024, revealed that the resident had behavioral issues that included hitting others, screaming, combative with care, attempting to bite staff, resistance to care and wandering. The goal was for the resident to have fewer episodes of behavior. Interventions included to approach the resident in a calm manner, document behaviors, allow the resident to calm when resistive or combative, monitor the resident during episodes of behavior, notify physician if behavior escalates, provide diversional activities and provide increased supervision.</p> <p>Review of Resident R55's progress notes revealed a psychiatry (mental health) note, dated September 20, 2024, which indicated that the resident was mostly nonverbal, confused, minimal interaction and minimal engagement due to advanced dementia. The resident did not show any signs of agitation or aggression at the time of the exam.</p> <p>Review of Resident R55's progress notes from September 20 through September 23, 2024, revealed that the resident was on one-to-one supervision with staff and that the resident did not have any behavioral issues. Continued review revealed a nurses note, dated September 24, 2024, at 6:25 a.m. indicated that the resident had occasionally aggressive behavior and that the resident was able to be redirected; the resident then went to sleep after the behavioral episode.</p> <p>Continued review of Resident R55's progress notes from September 25 through October 5, 2024, revealed that the resident was on one-to-one supervision with staff and that the resident did not have any behavioral issues. Continued review revealed a nurses note, dated October 6, 2024, at 2:20 p.m. which indicated that the resident had an episode of aggressive behavior towards staff and that staff were able to calm the resident down with redirection; the resident then went to sleep after the behavioral episode.</p> <p>Continued review of Resident R55's progress notes from October 8 through 17, 2024, revealed that the resident continued on one-to-one supervision with staff and that the resident did not have any behavioral issues.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of Resident R55's progress notes revealed a nurses note, dated October 17, 2024, at 1:57 p.m. which indicated that the resident was asleep during the shift and did not have any negative behaviors. Another note dated October 17, 2024, at 5:43 p.m. indicated that the resident was transferred to a mental health hospital at 12:30 p.m. via emergency medical services.</p> <p>Further review of Resident R55's clinical record revealed that there was no documentation or indication as to why the resident was transferred to a mental health hospital. There was no indication that the facility was unable to meet the resident's needs or that the health and safety of individuals at the facility were endangered due to the resident's status.</p> <p>Interview on October 31, 2024, at 10:10 a.m. Employee E11, unit manager, revealed that she did not know why Resident R55 was transferred to a mental health hospital. Employee E11, unit manager, confirmed that there were no notes or indication in the resident's clinical record as to why the resident was sent to the mental health hospital.</p> <p>Interview on October 31, 2024, at 10:35 a.m. Employee E20, nurse aide, confirmed that she was on duty the day that Resident R55 was transferred to the mental health hospital. Employee E20, nurse aide, stated that the resident did not have any behaviors that day and described the resident as calm. Employee E20, nurse aide, stated that Resident R55 previously had behaviors but that she thought that her behaviors were improving as she was becoming more familiar with staff.</p> <p>Interview on October 31, 2024, at 10:43 a.m. the Director of Nursing (DON) confirmed that there was no documentation to explain why Resident R55 was transferred to a mental health hospital. The DON confirmed that the resident was calm with no documented behaviors on the day of her transfer and that no acute events or change in the resident's status occurred that would warrant a transfer to a hospital. The DON was unable to provide evidence that Resident R55's transfer was necessary for the resident's welfare, that the facility was unable to meet the resident's needs or that the health and safety of individuals at the facility were endangered due to the resident's status. The DON stated that facility was unwilling to continue to provide ongoing one-to-one supervision for Resident R55.</p> <p>28 Pa Code 201.18(b)(2) Management</p> <p>28 Pa Code 211.5(f)(ix) Medical records</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers to the hospital and that a resident's representative was made aware of a facility-initiated transfer, for four of four residents reviewed related to transfers (Residents R65, R54, R94 and R55).</p> <p>Findings Include:</p> <p>Review of progress notes for Resident R65 revealed a note, dated September 9, 2024, at 8:00 p.m. which indicated that the resident had a fall and was transferred to a local hospital for evaluation.</p> <p>Review of progress notes for Resident R54 revealed a note, dated September 16, 2024, at 5:13 p.m., which indicated that the resident had a fall and was transferred to a local hospital for evaluation.</p> <p>Clinical record review for Resident R94 revealed a nurses note, dated September 24, 2024, at 7:34 p.m. which indicated that the resident had abnormal labs. The practitioner was notified and ordered for the resident to be transferred to a local hospital for further evaluation.</p> <p>Further record reviews for Residents R65, R54, and R94 revealed that no documentation was available for review at the time of the survey to indicate that the Office of the State Long-Term Care Ombudsman was notified of the facility-initiated emergency transfers and discharges.</p> <p>Review of documentation provided by the Nursing Home Administrator on October 28, 2024, revealed the Office of the State Long Term Care Ombudsman was not made aware Resident R65, R54, and R94's facility-initiated emergency transfers to the hospital as required.</p> <p>Review of Resident R55's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 9, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) and encephalopathy (brain damage). Continued review revealed that the resident was moderately cognitively impaired.</p> <p>Review of Resident R55's progress notes revealed a psychiatry (mental health) note, dated September 20, 2024, which indicated that the resident was mostly nonverbal, confused, minimal interaction and minimal engagement due to advanced dementia. The resident did not show any signs of agitation or aggression at the time of the exam.</p> <p>Review of Resident R55's progress notes revealed a nurses note, dated October 17, 2024, at 1:57 p.m. which indicated that the resident was asleep during the shift and did not have any negative behaviors. Another note dated October 17, 2024, at 5:43 p.m. indicated that the resident was transferred to a mental health hospital at 12:30 p.m. via emergency medical services.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Interview on October 31, 2024, at 10:43 a.m. the Director of Nursing (DON) confirmed that there was no documentation to explain why Resident R55 was transferred to a mental health hospital. The DON confirmed that the resident was calm with no documented behaviors on the day of her transfer and that no acute events or change in the resident's status occurred that would warrant a transfer to a hospital. The DON confirmed that there were no notes or indication in the resident's clinical record that Resident R55's representative was notified of the transfer to the mental health hospital at the time of the resident's transfer.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed provide appropriate bed hold notice to a resident's representative of a facility-initiated transfer to the hospital for one of four residents reviewed related to transfers (Resident R55).</p> <p>Findings include:</p> <p>Review of Resident R55's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 9, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) and encephalopathy (brain damage). Continued review revealed that the resident was moderately cognitively impaired.</p> <p>Review of Resident R55's progress notes revealed a psychiatry (mental health) note, dated September 20, 2024, which indicated that the resident was mostly nonverbal, confused, minimal interaction and minimal engagement due to advanced dementia. The resident did not show any signs of agitation or aggression at the time of the exam.</p> <p>Review of Resident R55's progress notes revealed a nurses note, dated October 17, 2024, at 1:57 p.m. which indicated that the resident was asleep during the shift and did not have any negative behaviors. Another note dated October 17, 2024, at 5:43 p.m. indicated that the resident was transferred to a mental health hospital at 12:30 p.m. via emergency medical services.</p> <p>Review of Resident R55's clinical record with Employee E11, unit manager, on October 31, 2024, at 11:10 a. m. revealed that there was no bed hold notice available for review in the resident's record. Employee E11, unit manager, confirmed that there were no progress notes nor paper documents which indicated that Resident R55's representative was provided with written information that specified the duration of the state bed-hold policy at the time of the resident's transfer to the hospital.</p> <p>On October 31, 2024, at 11:22 a.m. the Director of Nursing (DON) presented a Bed Hold and In-House Transfer Policy form for Resident R55. Review of the form revealed that there was no duration for bed hold specified on the form. Further review revealed that the form was signed by a registered nurse in the space designated where it should be signed by the resident or their representative. The DON was unable to explain who signed the form and confirmed that the form was signed by a registered nurse in the place where it should have been signed by the resident or her representative. The DON could not specify the name of the nurse who signed the form. The DON confirmed that there was no duration of bed hold days entered on the form. The DON confirmed that there was no documentation available for review at the time of the survey to indicate that the resident or her representative was notified of the bed hold policy at the time of the resident's transfer to the hospital. The DON confirmed that there was no documentation by any nurses that the information on the form was reviewed with the resident or her representative at the time of her transfer to the hospital.</p> <p>28 Pa Code 201.18(b)(2) Management</p> <p>(continued on next page)</p>		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.5(f)(ix) Medical records 28 Pa Code 211.12(d)(1) Nursing services

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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>43277</p> <p>Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to develop a person-centered comprehensive care plan related to behaviors for one of 23 residents reviewed (Resident R63).</p> <p>Findings Include:</p> <p>Review of facility policy Care Plan - Interdisciplinary Plan of Care from Interim to Meeting dated February 2024 revealed the care plan describes or includes adequate information provided to make informed choices regarding treatment.</p> <p>Review of Resident R63's clinical record revealed a physician order dated March 17, 2024, for 1:1 supervision every shift.</p> <p>Interview on October 29, 2024, at 3:35 p.m. with the Director of Nursing, Employee E2, revealed Resident R63 required indefinite 1:1 supervision due to history of sexually inappropriate behaviors.</p> <p>Review of Resident R63's clinical record and review of past survey history confirmed Resident R63 had a behavior of being sexually inappropriate with other female residents.</p> <p>Review of Resident R63's comprehensive care plan dated August 8, 2019, revealed the resident was physically inappropriate to another resident. The care plan was not specific to address Resident R63's behavior of being sexually inappropriate with other female residents.</p> <p>Interview on October 31, 2024, at 8:49 a.m. with the Director of Nursing, Employee E2, confirmed Resident R63's comprehensive care plan did not specify history of sexually inappropriate behaviors.</p> <p>28 Pa. Code 211.10 (d) Resident care policies.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48347</p> <p>Based on review of facility policy, facility documentation, review of clinical records, observation, Pennsylvania code title 49 professional and vocational standards and staff and resident interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice related to safe and timely medication administration for two of eight residents observed.</p> <p>(Residents R99, and R57)</p> <p>Findings include:</p> <p>Review of facility policy titled Medication Dispensing System dated April 1, 2018, revealed all medication will be prepared and administer in a manner consistent with the general requirements outlined in the policy medications are to be administered in a timely fashion.</p> <p>Review of Policy titled Medication Administration Policy Times revealed that unless specified by the physician, medications will be administered within sixty minutes before or after the facility dosing schedule, except before or after meals orders and non-routine time ordered medications. The medications administration pass may begin sixty minutes before the scheduled times, and administration of medications may exceed sixty minutes after the schedule.</p> <p>Medications ordered to be given before meals are administered approximately thirty minutes before mealtime. Medications ordered to be given after meals are given no later than 30 minutes after meal has ended.</p> <p>Review of the Pennsylvania code title 49 professional and vocational standards Department of state chapter 21 state board of nursing chapter 21.1455 Functions of an LPN (licensed practical nurse) requires the following: (a) the LPN is prepared to function as a member of the health care team by exercising sound nursing judgment based on preparations knowledge skills understandings and past experiences in nursing situations. LPN participates in planning implementation and evaluation of nursing care in settings where nursing take place. (b) the lpn administers medication and carry and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) the Board recognizes codes of behavior as developed by appropriate practical nursing associations as criteria for assuring safety and effective practice</p> <p>Review of Resident R57's clinical record revealed that Resident R57 has diagnosis' including paraplegia (paralysis of lower parts of the body), type one diabetes (chronic autoimmune disease that prevents the pancreas from making insulin), and anxiety(mental health disorder characterized by feelings of worry or fear) . Further review of Resident</p> <p>R 57's clinical record revealed a physician order for Insulin Lispro 100 unit/ML, dated October 9, 2024, with instruction to inject 12 units subcutaneously with breakfast and Inject 14 units subcutaneously before lunch, and inject 17 units in the evening before dinner.</p> <p>Review of the posted meal posted serving times:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>breakfast start 7:45am: 1st floor 8:00a.m./8:15a.m./8:30a.m. - 2nd 8:45a.m./9:00a.m.</p> <p>lunch start 11:45: 1st floor 12:00p.m./12:15p.m. - 2nd 12:30p.m./12:24p.m./1:00p.m.</p> <p>dinner start 5:00: 1st floor 5:15p.m./5:45p.m. - 2nd 5:30p.m./6:00p.m./6:15p.m.</p> <p>Interview with Resident R57 on October 28, 2024, at 10:08 a.m. revealed that she has not received her insulin at the time of interview, Resident R57 stated that the insulin was supposed to be given with breakfast.</p> <p>According to the meal schedule provided, the resident resides on the second-floor nursing unit and received her breakfast at 8:45-9:00 a.m.</p> <p>Interview with Licensed nurse, Employee E13 on October 28, 2024, at 10:18 a.m. confirmed that she has not administered Resident R57 the insulin at time of interview. Employee E13 confirmed that the medication is late.</p> <p>Review of resident R99's clinical record revealed that Resident R99 has diagnosis' including of dorsalgia (back pain), hypertension (high blood pressure), type two diabetes(medical condition when the body does not produce enough insulin causing high blood sugars), major depressive disorder(mental health disorder characterized by persistent feeling of sadness and loss of interest).</p> <p>Review of Resident R 99's medication administration record for the morning of October 28, 2024, revealed that licensed nurse Employee E13 dispensed and administered 40 mg, lisinopril 10 mg, hydroxyzine 25 mg, and methocarbamol 500 mg to Resident R 99.</p> <p>Further review of Resident R99'scare plan revealed that Resident R99 has been assessed and determined to have behavior problems including aggression and has been confrontational.</p> <p>Observation of resident R99 on October 28, 2024, at 10:00a.m. revealed the resident entering the room and throwing his medication on the bed stating they are the wrong medications. Resident was asked where he got the medications, Resident R99 replied the nurse in the hall gave him the medication cup containing the pills. Resident R99 stated that the medications are always just left on the bedside table.</p> <p>Interview with Licensed nurse, Employee E13 on October 28, 2024 at 10:05 a.m. confirmed that she gave Resident R99 the cup of medication pills in the hall and Resident R 99 walked away with them.</p> <p>28 Pa. Code 210.14(a) Responsibility of licensee</p> <p>28 Pa Code 211.12 (d)(1)(2) Nursing Services</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of clinical records, review of facility documentation, and staff and resident interviews, it was determined that the facility failed to provide adequate staff supervision and failed to maintain a resident environment free of potential accident hazards relating to a resident gaining access to an exit door. (Resident R 306)</p> <p>Findings include:</p> <p>Review of facility policy titled Incident and Accident Policy and Procedure updated October 2024, revealed that the purpose of the policy is to outline the procedure for managing, reporting, and investigation incidents and accidents involving residents in long term care facilities.</p> <p>Continued review of the policy stated that an Incident is defined as unexpected or unplanned event that does not result in injury or harm but has the potential to do so. The policy is implemented to ensure prompt and appropriate responses to incidents and accidents involving residents, minimize the risk of harm to residents through preventative measures and establish a clear process for reporting, investigating and documenting incidents. Further review of this policy states the administrator will review incident reports and investigate outcomes.</p> <p>The resident will be provided immediate care and assistance following incidents. The Administrator, nursing and care staff, the director of nursing, human resources, facility administration, resident, and family members, are all included in the Prevention and risk management.</p> <p>Review of Resident R306's clinical record revealed that Resident R306 was admitted into the facility on [DATE] with diagnoses of cellulitis of the leg, sepsis (the body's extreme response to an infection, can be life threatening), anemia (blood disorder resulting in low red blood cells), history of substance abuse (drug abuse), and cerebral infarction(stroke). Resident 306's medication included Adderall, Zolpidem, Oxycodone, and Morphine. Resident R306 was determined to have opioid seeking behaviors requesting additional dosages.</p> <p>Review of Residents R306's care plan revealed resident is at risk for and demonstrates unusual behaviors at times related to history of poly substance abuse and IVDA (intravenous drug use) dated May 30, 2024, consisting of interventions including analyze of key times, places, circumstances, triggers and what deescalates behavior and document dated May 30, 2024.</p> <p>Continued review of Resident 306's care plan dated June 13, 2024, revealed resident was able to get off the unit and is at risk at risk for similar incidents /elopement. Interventions of this focus is to ensure that the Wander Guard bracelet is placed and checked for functioning created on June 20, 2024, and monitor residents whereabouts closely for safety. All care and communication with resident must be done by a minimum of two people present for safety document any behaviors or noncompliance, dated August 29, 2024.</p> <p>(continued on next page)</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>Continued review of Resident R306's care plan revealed the resident has behavior problems and can be non-compliant with facility policy and procedure at times, resident can be verbally aggressive towards staff, resident has argumentative behaviors, accusatory behaviors towards staff and residents. Resident with a tendency to wander dated July 8, 2024, with intervention to monitor residents' behaviors and document.</p> <p>Review of Resident R306's physician orders dated October 25, 2024, revealed an order for an Electronic Wander Bracelet: Check placement daily every shift.</p> <p>Review of Resident R306's clinical record progress note titled behavior note dated October 28, 2024 revealed Resident buzzed herself out at the front desk at 11 pm yesterday and went outside to smoke, she came back into the building when oncoming staff were entering the building, resident was asked to give the cigarette and lighter to the nurse, but she said she didn't have any on her person, she denied being outside, even though she was seen smoking by off-going staff.</p> <p>Observation of reception desk on October 30, 2024, at 8:45 a.m. revealed attendant using a device under the desk to allow surveyor in the building. Interview with desk attendant revealed that the door must be buzzed, or numerical code is required to always open the doors.</p> <p>Interview with Resident 306 on October 29, 2024, at 11:15a.m. revealed that she does not wear any kind of security monitor. Resident R306 stated that she knows the security code to exit the building. She verbalized that she has left the building multiple times to smoke.</p> <p>Interview with Licensed nurse, Employee E24 on October 29, 2024, at 11:10 am, revealed that this employee is aware of Resident 306's noncompliance with rules and has been made aware of incidents related to Resident 306 has left the building to smoke at unsecured times. He has never witnessed the behavior while during the day shift.</p> <p>Interview with NHA Employee E1 and DON, Employee E2 on October 30, 2024, at 9:25 a.m. confirmed that the code to exit the building was discovered by a resident shared the information with other residents, leading to resident R306 obtaining the code to exit Since then, NHA, Employee E1 has change the code. Employee E1 was unaware of Resident 360 leaving the building on October 27, 2024, after 11:00 p.m.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. 211.12 (d)(5) Nursing Services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observations, review of clinical records, review of facility policy and interview with staff, it was determined that the facility failed to administer oxygen as ordered by the physician for one of one resident receiving oxygen therapy. (Resident R61)</p> <p>Findings include:</p> <p>Review of facility Policy on Oxygen Administration with a revised date of April 1, 2015, revealed that under section Policy it is the policy of this facility to provide comfort to residents by administering oxygen when insufficient oxygen is being carried by the blood to the tissue. Under section Procedure. #1 check physicians order for litter flow and method of administration. #7 All oxygen tubing is changed weekly and dated.</p> <p>Review of Resident R61's clinical record reviewed that Resident R61 was admitted to the facility on [DATE], with diagnoses of Chronic Obstructive Pulmonary Disease (disease process that causes decreased ability of the lungs to perform), Acute Pulmonary Edema, Hypertension (high blood pressure), Morbid Obesity.</p> <p>Review of Resident R61's quarterly MDS (minimum data set-a federally required resident assessment completed at a specific interval) Section C0500 Brief Interview for Mental Status revealed that Resident R61 scored 15 suggesting that Resident R61 was cognitively intact.</p> <p>Review of Physician's orders dated October 8, 2024, revealed an order for: Oxygen at 4 LPM (liters per minute) via NC (nasal cannula) continuously every shift for Shortness of Breath/COPD.</p> <p>Observation conducted on October 28, 2024, at 9:41 am, revealed that Resident R61 was in bed with Oxygen via nasal cannula connected to an Oxygen concentrator located on the floor against the wall towards the foot of Resident R61's bed.</p> <p>Further observation revealed that the Oxygen gauge when read at eye level was at 3.5 liters/minute.</p> <p>Interview with Unit Manager Employee E11 conducted at the time of observation confirmed that oxygen level was at 3.5 liters/minute. Further Unit Manager revealed that the oxygen level should be at 4 liters/minute.</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>39344</p> <p>Based on review of facility documentation, personnel records and interviews with staff, it was determined that the facility failed to complete annual performance reviews for nurse aide staff as required for three of five nurse aide personnel files reviewed (Employees E14, E16 and E18).</p> <p>Findings include:</p> <p>Review of facility documentation provided at the time of the survey pertaining to employee names, titles and dates of hire, revealed that Employee E14 was hired by the facility on June 22, 2003, as a nurse aide; Employee E16 was hired by the facility on January 17, 2017, as a nurse aide; and Employee E18 was hired by the facility on January 12, 1998, as a nurse aide.</p> <p>Review of Employees E14, E16 and E18's personnel files revealed that annual performance reviews were not available for review at the time of the survey.</p> <p>Interview on October 29, 2024, at 3:10 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) revealed that they were unsure if the facility had conducted any performance reviews for Employees E14, E16 and E18.</p> <p>Follow-up interview on October 30, 2024, at 8:46 a.m. the NHA and DON revealed that they were still looking for performance reviews for Employees E14, E16 and E18.</p> <p>No performance reviews for Employees E14, E16 and E18 were provided for review at any time during the survey.</p> <p>28 Pa. Code 201.19(2) Personnel policies and procedures</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure proper monitoring and documentation of behaviors for two of 23 residents reviewed (Residents R40, and R6).</p> <p>Findings include:</p> <p>Review of Resident R40's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated August 15, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including schizophrenia (mental illness associated with loss of reality contact, delusions and hallucinations).</p> <p>Review of Resident R40's care plan, dated September 19, 2022, revealed that the resident had behaviors including aggression towards staff, use of profanity towards staff, refused consults, refused to wear proper footwear, refused to use assistive devices and that the resident responds to internal stimuli and may act on auditory hallucinations. Interventions included for staff to monitor and document the resident's behaviors, remind the resident to use his assistive devices, allow time to communicate effectively, discuss and honor the resident's refusals, and provide reassurance and try again when the resident is resistant to care.</p> <p>Review of progress notes for Resident R40 revealed a psychiatry (mental health) note, dated August 23, 2024, with recommendations to monitor and document behaviors to assist with psychotropic medication management as well as to utilize nonpharmacologic interventions and supportive care when needed.</p> <p>Continued review of progress notes for Resident R40 revealed eMAR notes (electronic Medication Administration Records) that indicated that behaviors were observed on September 4, 5, 8, 9, 10, 13, 14, 15, 20, 29, 30, 2024; and October 2, 5, 6, 7, 9, 13, 20, 26, 2024. The eMAR notes did not provide any additional information regarding the observed behaviors, such as type of behavior, what the resident was doing or any staff interventions implemented to address the behaviors.</p> <p>Review of Resident R6's Quarterly MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) and anxiety disorder (intense, excessive, persistent worry or fear).</p> <p>Review of Resident R6's care plan, dated January 4, 2023, revealed that the resident had behaviors including wandering, loud outbursts, hoarding, yelling, using profanity, refuses consults, refuses hair care and was not capable of understanding risks. Interventions included for staff to provide explanations of all care activities, encourage the resident to participate and honor the resident's refusal.</p> <p>Review of progress notes for Resident R6 revealed a psychiatry note, dated September 6, 2024, with recommendations to monitor and document behaviors to assist with psychotropic medication management as well as to utilize nonpharmacologic interventions and supportive care when needed.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of progress notes for Resident R6 revealed eMAR notes indicated that behaviors were observed on September 8, 9, 10, 13, 14, 15, 20, 29, 2024; and October 5, 6, 7, 9, 13, 20, 26, 2024. The eMAR notes did not provide any additional information regarding the observed behaviors, such as type of behavior, what the resident was doing or any staff interventions implemented to address the behaviors.</p> <p>Interview on October 30, 2024, the Director of Nursing stated that if a resident is having a behavior that nursing staff should enter a note regarding the behavioral episode.</p> <p>28 Pa Code 201.18(b)(2) Management</p> <p>28 Pa Code 211.5(f)(ix) Medical records</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on review of facility policy, review of facility documentation, review of clinical records, and staff interview, it was determined that the facility failed to ensure medication regimen reviews were completed monthly by a licensed pharmacist and failed to ensure recommendations were reviewed timely by the physician for 4 of 5 residents reviewed (Resident R88, R28, R6, and R40).</p> <p>Findings Include:</p> <p>Review of facility policy, Medication Regimen Review dated September 2023, revealed The Medication Regimen Review is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. Continued review revealed, The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. Continued review revealed, Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug and the irregularity the pharmacist identified. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. Further review revealed, Any written communications provided to the facility will be filed and any attachments in a readily retrievable area.</p> <p>During an interview with the Director of Nursing, Employee E2, on October 29, 2024, at approximately 3:30 p. m., surveyors requested six months of medication regimen reviews completed by a licensed pharmacist for the following residents: Resident R88, R28, R6, and R40.</p> <p>Review of documentation provided by the Director of Nursing, Employee E2, and review of Resident R88's entire clinical record revealed no documented evidence a licensed pharmacist conducted a complete medication regimen review for Resident R88 for June or July 2024.</p> <p>Review of documentation provided by the Director of Nursing, Employee E2, and review of Resident R6's entire clinical record revealed no documented evidence a licensed pharmacist conducted a complete medication regimen review for Resident R6 for June or July 2024.</p> <p>Review of documentation provided by the Director of Nursing, Employee E2, and review of Resident R40's entire clinical record revealed no documented evidence a licensed pharmacist conducted a complete medication regimen review for Resident R40 for July 2024.</p> <p>Review of Resident R40's Consultant Pharmacist Medication Regimen Review, dated June 29, 2024, revealed recommendations to review the resident's antidepressant medication for a possible dose reduction. The physician did not sign that the recommendation was reviewed until August 26, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R28's monthly pharmacy review provided by Employee E2 on October 30, 2024, at 9:19am revealed that there were pharmacy reviews for May 22, 2024, July 28, 2024, August 25, 2024, and September 24, 2024.</p> <p>Interview with Employee E2 conducted on October 30, 2024, at 9:19 a.m. revealed that there was no pharmacy review for April 2024, June 2024 and October 2024 for Resident R28.</p> <p>Continued interview with the Director of Nursing, Employee E2, on October 20, 2024, at 9:36 a.m. revealed that she was hired by the facility in August 2024, and that she was unable to retrieve any data from the consultant pharmacist prior to September 2024.</p> <p>28 Pa Code 211.2(d)(3) Medical director</p> <p>28 Pa Code 211.9(k) Pharmacy services</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>48347</p> <p>Based on review of facility policy, clinical record review, and review of facility documentation, it was determined that the facility failed act upon pharmacist recommendation and provide a rationale for continued use of medication. (resident R21)</p> <p>Findings include:</p> <p>Review of facility policy titled Medication Regimen Review dated September 2023, revealed that the medication regime review is a thorough evaluation of the medication regime of a resident with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing identifying reporting and resolving medication related problems medication errors and other irregularities and collaborating with other members of the inner disciplinary team.</p> <p>Any irregularities noted by the pharmacist during this review must be documented on a written report and is sent to the attending physician. The attending physician must document in the residence medical record the identified irregularity has been reviewed and if any action has been taken to address it there is if there is to be no change in the medication the attending physician should document his or her rationale in the residence medical records.</p> <p>Review of manufacture [NAME] medication Amitriptyline Hydrochloride insert revealed that this medication is an antidepressant with sedation effects, used to relieve symptoms of depression. Patients with major depressive disorder may experience worsening of the depression and or the emergence of suicide ideation and behavior unusual changes. Patients being treated with antidepressants for any indication should be monitored appropriately and observe closely for clinical worsening. Side effects of this medication may include symptoms of anxiety, agitation, panic attack, insomnia, irritability, hostility, aggressiveness, impulsiveness, hypomania, and mania. Patients being treated with antidepressants for major depressive disorder as well as other indications consideration should be given to changing therapeutic regime including possibility of discontinuing the medication.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident r 21 clinical record revealed resident R 21 was admitted into the facility October 16, 2023 with diagnosis including unspecified psychosis, major depressed disorder, and alcohol abuse. Review of residence clinical record revealed the resident was admitted to the facility and had diagnosis including.</p> <p>Review of facility documentation of pharmacy review dated July 28, 2024, revealed an evaluation of resident R 21's medication regime consisting of the antidepressant drug Amitriptyline. The pharmacist recommendation of this evaluation requested a rationale of risk verses benefits of continuation of the drug. Continued review of this documentation revealed that the physician referred the recommendation to psychology for further review. This document was signed by the physician and faxed on August 26, 2024.</p> <p>Review of resident R21 clinical record psychology, and psychiatry notes revealed the last notation in resident 21' chart was dated June 14, 2024. Continued review of resident R 21's clinical record revealed note response or notation addressing pharmacist recommendation.</p> <p>Review of resident R 21's physician orders revealed resident an order for medication Amitriptyline oral tablet 10 mg instructed to give 30 mg by mouth dated September 16, 2024.</p> <p>28 Pa code 211.2(a) Physician Services</p> <p>28 Pa Code 211.9(K) Pharmacy services</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>43277</p> <p>Based on observations, review of facility documentation, and staff and resident interviews, it was determined that the facility failed to ensure menus were followed and provided variety for two of two nursing units observed (1st and 2nd floor nursing units).</p> <p>Findings Include:</p> <p>Review of the facility Spring/Summer Menu 2024 Week 1 (menu for the week of survey) revealed on Monday October 28, 2024, apple cinnamon oatmeal and French toast was on the menu for breakfast.</p> <p>Observations in the main kitchen on October 28, 2024, at 8:45 a.m. revealed dietary staff preparing breakfast meal trays for the residents via a tray line system. Further observations revealed no apple cinnamon oatmeal was available.</p> <p>Interview on October 28, 2024, at 8:45 a.m. with the Food Service Director, Employee E21, confirmed Apple Cinnamon Oatmeal was on the menu for breakfast but was unavailable. Further interview with the Food Service Director, Employee E21, revealed cream of wheat was being served instead.</p> <p>Continued observations on October 28, 2024, during breakfast tray line revealed toward the end of tray line approximately 5-6 residents were served waffles instead of french toast.</p> <p>Surveyor requested a test tray of the regular meal on October 28, 2024, during the breakfast meal. The surveyor was provided with waffles instead of French Toast.</p> <p>Interview on October 29, 2024, at 9:30 a.m. with the Regional Food Service Manager, Employee E22, confirmed the kitchen ran out of french toast in the middle of breakfast service on October 28, 2024, and needed to serve waffles instead.</p> <p>Review of the facility menu revealed that on Monday October 28, 2024, yellow cake with topping was on the menu to be served with lunch.</p> <p>Observations on the second floor nursing unit on October 28, 2024, at 12:35 p.m. revealed that residents did not receive the yellow cake with topping, nor any other dessert, with their lunch meal. Interview, at the time of the observation, Employees E9 and E10, nurse aides, confirmed that the residents on the second floor nursing unit did not receive the yellow cake with topping with their lunch as posted on the menu.</p> <p>Further review of the facility menu revealed on Tuesday, October 29, 2024, Southern Style Fried Chicken was on the menu for the lunch.</p> <p>Observations in the main kitchen on October 29, 2024, at 12:54 p.m. during the lunch meal service revealed the kitchen ran out of fried chicken while plating lunch trays for the 2nd floor residents and began to serve chicken patties instead.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on October 29, 2024, at 12:54 p.m. with the Food Service Director, Employee E21, confirmed the kitchen did not have enough fried chicken to serve the residents on the 2nd floor.</p> <p>Interview on October 28, 2024, at 9:27 a.m. Resident R18 stated that the menus are repetitive and that the facility does not listen to residents ' requests during resident council and food committee meetings.</p> <p>Interview on October 28, 2024, at 10:07 a.m. Resident R85 stated that there was not enough variety on the menu and that the facility serves too much pork.</p> <p>Interview on October 28, 2024, at 10:21 a.m. Resident R19 stated that the facility often runs out of food and that she often does not receive the items that are on the posted menu. Resident R19 stated that the menus are repetitive and that the facility serves too much pork.</p> <p>Review of the facility Spring/Summer Menu 2024 Week 1 (menu for the week of survey) revealed on Monday October 28, 2024, and Wednesday October 30, 2024, the lunch meal was pork with gravy and zucchini, which confirmed a lack of variety and repetitiveness of meals.</p> <p>28 Pa. Code 211.6(a) Dietary services</p> <p>28 Pa. Code 201.4(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Towne Manor East		STREET ADDRESS, CITY, STATE, ZIP CODE 2004 Old Arch Road Norristown, PA 19401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure that food was palatable and served at appetizing temperatures.</p> <p>Findings include:</p> <p>A test tray was completed on October 28, 2024, at 9:15 a.m. with Food Service Director, Employee E21, on the second-floor nursing unit, during the breakfast meal service. The outcome of the test tray revealed the following: waffles were 108.7 degrees Fahrenheit (F), bacon was 86.7 degrees F, and the hard-boiled egg was 97.3 degrees F. A taste test of the food items revealed the food was cold and unappetizing to taste. The waffles were tough and chewy, making them difficult to eat.</p> <p>Interview on October 28, 2024, at 9:27 a.m. Resident R18 stated that the food does not taste good and that he often buys his own food because he is unable to eat the facility's food.</p> <p>Interview on October 28, 2024, at 9:50 a.m. Resident R23 stated that the food is often served cold and does not taste good.</p> <p>Interview on October 28, 2024, at 10:21 a.m. Resident R19 stated that the food is often served cold and cooked too hard.</p> <p>Interview on October 28, 2024, at 11:03 a.m. Resident R38 stated that the food is often served cold.</p> <p>Interview on October 28, 2024, at 12:07 p.m. with Resident R50 revealed the food was not appetizing. Observations revealed Resident R50 was just served lunch and was scraping the gravy off the pork. The gravy used for the pork was congealed and appeared unappetizing.</p> <p>Interview on October 28, 2024, at 1:51 p.m. Resident R94 stated that the food is often served cold, that it tastes disgusting and that she misses a lot of meals because she is unable to eat the facility's food.</p> <p>Review of Resident R9's clinical record revealed that resident was admitted to the facility on [DATE], with diagnoses of but not limited to schizoaffective disorder, Malignant Neoplasm, Type 2 Diabetes Mellitus.</p> <p>Review of Resident R9's quarterly MDS (minimum data set-a federally required resident assessment completed at a specific interval) Section C0500. BIMS Summary Score revealed a score of 11, suggesting that resident was moderately impaired in cognition.</p> <p>Interview with Resident R9 conducted on October 28, 2024, at 8:49 am revealed that Resident R9 complained that the food in the facility did not taste good and that food could be better. Further, Resident R9 also complained that the food was served cold.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R35's clinical record revealed that resident was admitted to the facility on [DATE], with diagnoses of but not limited to schizoaffective disorder, major depressive disorder, anxiety disorder.</p> <p>Review of Resident R35's quarterly MDS (minimum data set-a federally required resident assessment completed at a specific interval) Section C0500. BIMS Summary Score revealed a score of 15, suggesting that resident was cognitively intact.</p> <p>Interview with Resident R35 conducted on October 29, 2024, at 9:32 am revealed that Resident R35 complained the food in the facility was not good and that the food was always cold.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>43277</p> <p>Based on observations, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to serve foods that accommodate residents' allergies, intolerances and preferences for one of 23 reviewed (Residents R11).</p> <p>Findings include:</p> <p>Review of progress notes for Resident R11 revealed a nutrition note, dated September 17, 2024, at 2:33 p. m. which stated, Food preferences obtained, resident does not eat pork.</p> <p>Observation of the menu posted on the second floor nursing unit on October 28, 2024, revealed that the lunch meal was roast pork with gravy, roasted zucchini, mashed potatoes and yellow cake with topping. The alternate meal was baked chicken with brown gravy.</p> <p>Interview on October 28, 2024, at 12:39 p.m. Resident R11 stated that he was not able to eat his lunch. Observation, at the time of the interview, revealed that the resident was served pork. Continued observations revealed that the resident did not eat his meal and was not offered the alternate lunch item.</p> <p>Interview on October 30, 2024, at 8:45 a.m. with nurse aide, Employee E23, revealed the food menus for breakfast/lunch/dinner are posted at the elevators. Per the interview, some residents can get to the elevators to see what is being served for the day and request what they want. However, residents who do not have this capability (such as residents who stay in their rooms), do not have the opportunity to see what is on the menu for the day to be able to make a choice.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</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** 43277</p> <p>Based on review of facility policy, observations in the food and nutrition department, and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, and served in accordance with professional standards for food service safety.</p> <p>Findings Include:</p> <p>Review of facility policy Food Storage dated August 2024, revealed food items will be stored, thawed, and prepared in accordance with good sanitary practice. All products shall be dated upon receipt or when they are prepared. Further review of facility policy revealed meat should be dated when taken out of the freezer. Dented cans should be placed on damaged good shelf and returned for credit. Any opened products shall be placed in containers with tight-fitting lids or Ziploc bags. All foods shall be stored off the floor.</p> <p>A tour of the main kitchen was conducted with the Food Service Director, Employee E21, on October 28, 2024, at 8:45 a.m. revealed the following:</p> <p>Interview with the Food Service Director, Employee E21, revealed a food order was received in the morning around 6:30 a.m. that was unable to be put away yet. Observations revealed a box of frozen French fries, frozen waffles, tomatoes, and apple juice cups were stored directly on the kitchen floor.</p> <p>Observations in dry storage revealed a reach-in refrigerator. Observations inside the reach-in refrigerator revealed 4 sheet cakes with no dates, a moldy cucumber, a box of individual cream cheese portions on the bottom shelf with a dark, liquid dripping all over the box, 7 heads of lettuce with no date and was starting brown/[NAME]. Further observations revealed two large pork loins and a box of chicken thighs with no dates. Per the food service director, the meats were previously frozen and put in the fridge to thaw.</p> <p>Continued observations in dry storage revealed a box of bananas stored on top of a plastic milk crate. Further observations revealed the bananas were extremely overripe and deteriorating. The food service director picked up the box of bananas to remove from the dry storage room and a swarm of fruit flies scattered throughout the dry storage room.</p> <p>On the shelving in dry storage there was a bag of sugar that was open to air and not put in a sealed, air-tight container.</p> <p>Further observations in dry storage revealed two cans of dented sweet potato cans that were not in a designated damaged goods area.</p> <p>Observations of the reach-in freezer revealed the freezer was tightly packed, limiting adequate circulation of air around the food. Further observations of the reach-in freeze revealed an open, and undated container of hot dogs. The bottom of the reach-in freezer had significant food and debris build up that required cleaning.</p> <p>(continued on next page)</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>Observations of the walk-in refrigerator revealed pineapples in a plastic storage container with no date.</p> <p>Observations above the prep sink revealed a long shelf along the wall storing condiments. Observations revealed a container of teriyaki sauce with drippings on the outside of the container making it sticky to touch. Behind the wall of the shelf were dark, dried liquid drippings down the wall. The shelf had a significant build-up of grease, food, and debris. Fruit flies were present and flying above the prep sink.</p> <p>The microwave was greasy to touch.</p> <p>Observations revealed the condiment cart used to store condiments to utilize during tray line was missing a wheel and was being held up by a small bin.</p> <p>Observations were confirmed by the Food Service Director, Employee E21, throughout the duration of the kitchen tour.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>46508</p> <p>Based on review of facility documentation and interviews with staff, it was determined that the facility failed to maintain an effective, comprehensive, data-driven quality assurance and performance improvement program (QAPI) that focuses on indicators of the outcomes of care and quality of life as required.</p> <p>Findings include:</p> <p>Review facility policy on Quality Assurance and Performance Improvement, Feedback, Data and Monitoring reveal that under section Policy: The QAPI program is based on the collection. Information obtained from data, self-assessment, and systems of feedback. Information is collected, evaluated, and monitored by the QAPI Committee. Under section Policy Interpretation and Implementation: #1 Information obtained about the quality of care and services delivered to residents is evaluated and monitored by the QAPI Committee In order to identify problems that are high risk, high volume, or problem prone and to guide decisions regarding opportunities for improvement. #2. The QAPI process focuses on identifying systems and processes that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality of life, resident safety, resident choice, or resident autonomy, and on making a good faith effort to correct or mitigate these outcomes.</p> <p>Review of facility QAPI documents revealed no documented evidence that deficient practices identified during previous State surveys where the plan of corrections included using the QAPI process to develop and implemented action plans to correct the identified quality deficiencies. Further there was no documented evidence that the previously identified quality deficiencies were resolved.</p> <p>Interview with facility Nursing Home Administrator conducted on October 31, 2024, at 8:48 a.m. revealed that he could not find any QAPI documentation from the previous administration for any of the previously identified quality deficiencies.</p> <p>Further Employee E1 also revealed that since his company took over, there was no QAPI conducted for deficiencies identified during the previous State surveys including those with plan of corrections that included conducting QAPI.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (b)(1) Management</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>46508</p> <p>Based on observation, interview with staff and review of facility policy and documents, it was determined that the facility failed to develop and implement a Water Management Program for the prevention, detection, and control of water borne contaminants, such as legionella (a bacteria that causes Legionnaire's Disease).</p> <p>Findings include:</p> <p>Review of facility policy entitled Legionella Water Management Program with a most recent revision date of September 2022, revealed that under section Policy: Our facility is committed to the prevention, detection of water borne contaminants, including Legionella. Further review of the facility's Policy on Legionella Water Management Program revealed that the policy did not include an assessment which includes a description of the building water systems using text and flow diagrams to identify where Legionella and other opportunistic waterborne pathogens could grow and spread.</p> <p>Review of facility documents revealed that the facility did not have a documented water management program based on nationally accepted standards.</p> <p>Further review of facility documents revealed that there was no documented evidence that the facility conducted an assessment which includes a description of the building water systems using text and flow diagrams to identify where Legionella and other opportunistic waterborne pathogens could grow and spread.</p> <p>Interview with Maintenance Director Employee E19 conducted on October 30, 2024, at 3:20 pm confirmed that the facility did not have a documented water management program in place. Further Employee E19 revealed that they had just hired a company to create the facility's Water Management Program.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>43277</p> <p>Based on observations, and staff interview, it was determined that the facility failed to maintain the kitchen in a sanitary environment to be free of pests.</p> <p>Findings Include:</p> <p>A tour of the main kitchen was conducted with the Food Service Director, Employee E21, on October 28, 2024, at 8:45 a.m.</p> <p>Observations in dry storage revealed a box of bananas stored on top of a plastic milk crate. Further observations revealed the bananas were extremely overripe and deteriorating (to the point that the bananas were beginning to liquify as evidenced by drippings beneath the box). The food service director picked up the box of bananas to remove from the dry storage room and a swarm of fruit flies scattered throughout the dry storage room.</p> <p>Interview with the Food Service Director, Employee E21, confirmed the bananas were the source of the fruit flies and should have been discarded.</p> <p>Observations above the prep sink revealed a long shelf along the wall storing condiments. Observations revealed a container of teriyaki sauce with drippings on the outside of the container making it sticky to touch. Fruit flies were present and flying above the prep sink.</p> <p>Interview with the Food Service Director, Employee E21, confirmed the presence of the fruit flies.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p>		