

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Ivory Wellness Center		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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Findings include: A tour of the Food Service Department was conducted on September 22, 2025, at 9:30 a.m. with Employee E3, Food Service Director (FSD), revealed the following concerns: Observation in the outdoor receiving area revealed 6 wooden pallets were leaning against the wall, and a large pile of black milk crates thrown to the left of the door. Observation of the convection oven revealed heavy build-up of black baked-on food particles on the inside surface of the oven. Observation of the reach in refrigerator in the kitchen revealed no internal thermometer to check temperature. Interview with the FSD on September 22, 2025, at 9:45 a.m. confirmed the above findings. Observation in the kitchen dish area during a follow up visit on September 23, 2025, at 1:30 p.m. revealed that the dishwasher wash temperature was 150 degrees and the rinse temperature was only 120 degrees. When asked why the rinse temperature was so low the FSD said that they just had their equipment and chemical company fixing the booster heater, but that it need another part. He said that they had been using the machine as a low temperature machine using a chlorine sanitizer, but it was disconnected when the booster heater was put in. Observation under the dish machine revealed clear plastic tubing laying on the floor next to a gallon jug of household bleach. The FSD removed the cap and put the tubing into the jug and ran the machine for a few minutes. After running several empty racks through the machine, he checked and the reading was still zero on chlorine as the bleach was not being pumped into the machine. An interview with the FSD on September 23, 2025, at 1:45 p.m. revealed that they had called the technician to come and check the machine. During this interview, the FSD confirmed that the chloring was not hooked up, that they should not be using household bleach and that they had not checked the chlorine level prior to washing the lunch dishes. An interview with the equipment and chemical company technician, Employee E13 on September 23, 2025, at 2:05 p.m. revealed that the sanitizer pump was not operating when he arrived and that he got the pump working and when tested, he got the minimum 50 ppm reading on chlorine. He also confirmed that the facility should not be using household bleach, but rather the sanitizer for commercial dish washing machines. An interview on September 23, 2025, at 2:20 pm with the Maintenance Director, Employee E12 revealed that he had been at the facility for thirty days and that he was aware that the dishwasher was being fixed and that it had been operating as a chemical sanitizer. 28 Pa. Code 201.14(a) Responsibility of licensee		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident interviews, it was determined that the facility failed to maintain the facility in a clean, safe, comfortable and homelike condition on both nursing floors. Findings include: Observations during the initial tour of the facility on September 22, 2025, revealed the following concerns: Observations on September 22, 2025, at 10:45 a.m., in room [ROOM NUMBER] in the bathroom revealed holes in the wall patched with a rough white substance and the bottom of the inside of the door had holes torn into the splintered wood door causing a hazardous condition. There was also flies buzzing around the room, Resident R23 said that he has seen the flies the last week or so. Observations on September 22, 2025, at 10:48 a.m., in room [ROOM NUMBER] revealed holes in the wall by the window patched with a rough white substance, and the ceiling tiles had dark brownish circular stains, some of which appeared to have been painted over with white paint. Observations on September 22, 2025, at 10:55 a.m., in room [ROOM NUMBER] revealed holes in the wall patched with a rough white substance. Observations on September 22, 2025, at 10:59 a.m., in room [ROOM NUMBER] revealed holes in the wall by the floor patched with a rough white substance and one entire wall covered with words and lyrics written in black marker. Observations on September 22, 2025, at 10:48 a.m., on September 22, 2025 in room [ROOM NUMBER] revealed holes in the wall near the floor between the beds patched with a rough white substance. Observations of Second floor unit on Monday, September 22, 2025, room [ROOM NUMBER], revealed cracked walls in multiple areas, near the window and air conditioning unit. Further observations of Second floor unit revealed six trash and laundry bins stored in the shower room as well as a mechanical lift. A discussion with the Administrator at 10:15 a.m. on September 25, 2025, confirmed the above findings. 28 Pa. Code 207.2(a) Administrator's responsibility		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based upon interviews with residents and staff and review of facility resident council minutes determined the facility failed to serve meals that were palatable, and at an appetizing temperature for nine of nine residents attending residents' group meeting (Resident R38, R39, R52, R68, R71, R77, R78, and R79), and one of 23 resident records reviewed (Resident R6). Findings include: On September 22, 2025, at approximately 1:00 p.m. during an interview with an alert and oriented resident, Resident R6 complained that the food during meals is Always served room temperature. Review of resident council minutes dated May 14, June 11, July 9, August 20, and September 10, 2025, revealed the residents voiced wanting more variety of meal alternatives, and concerns that during mealtime the food temperatures were not hot. Council minutes revealed the residents spoke to the facility administration and the food director regarding these food concerns. On May 14, 2025, it was documented that the Dietary Director expressed getting the food carts out sooner to keep the food hot. On July 9, 2025, the resident council minutes continued to note Multiple complaints of food being served cold and continued with the same complaint during the August 20, 2025, council meeting. On September 24, 2025, at 10:15 a.m. during an interview with nine alert and oriented residents from the facility's Resident council group, the residents all agreed the food continues to be served cold, and there is still no variety. These concerns were confirmed with the Director of Nursing on September 24, 2025, at 1:25 p.m. Interview with Resident R23 on September 22, 2025, at 10:34 a.m. revealed that he thinks that food is not good, too much chicken and rice is too thick, not always hot. Interview with Resident R28 on September 22, 2025, at 10:37 a.m. revealed that the food is not good, too much rice, small portions, not always warm. Interview with Resident R7 on September 22, 2025, at 10:40 a.m. revealed that food is not good, it is never warm, the hot water for tea is cold, will not make tea. Interview with Resident R73 on September 22, 2025, at 10:44 a.m. revealed that the food is really bad, the burgers are like rock, not always warm. Interview with Resident R89 on September 22, 2025, at 2:30 p.m. revealed that he stated I don't trust the food. It does not look good or smell good, I think they put something in it. I did not touch the lunch tray. Observations during a test tray conducted on September 24, 2025, revealed that the salad was served on the same plate as the spaghetti tray, causing the salad temperature to be 93 degrees and the spaghetti with meat sauce to be 118 degrees. The milk was at 52 degrees, and the fruit cup was at 70 degrees. Temperatures were taken by the Food Service Director (FSD), Employee E3, who confirmed that these foods were all outside the acceptable temperature range for palatability. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, a review of facility policy and documentation 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 and discharges for four of 26 clinical records reviewed (Residents R41, R115, R1 and R3). Findings include: A review of the Transfer or Discharge, Facility-Initiated policy, updated October 2022, revealed that a copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. Review of Resident R3's clinical record revealed that on June 18, 2025, the resident was sent out to hospital for evaluation due to low oxygen levels, low heart rate and high temperature. Further review of Resident R3's clinical record revealed the resident was hospitalized for 10 days and was re-admitted to facility on June 27, 2025. Review of facility provided documentation revealed no evidence that facility-initiated discharge for Resident R3 was communicate with long term care state ombudsman. Clinical record review for Resident R41 revealed that resident was admitted to the facility on [DATE], with diagnoses including end stage renal disease (kidneys can no longer function adequately to meet the body's needs, requiring dialysis or a kidney transplant for survival). Continued record review for Resident R41 revealed that the resident was sent to the hospital on July 27, 2025, with complications of refusing dialysis and was readmitted to the facility on [DATE]. A review of the list of residents sent to the Ombudsman for facility-initiated emergency discharged for July or August 2025 did not reveal Resident R41 was included in this notification. Closed clinical record review for Resident R115 revealed that resident was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (disorder of carbohydrate metabolism characterized by impaired ability of the body to produce or respond to insulin and thereby maintain proper levels of sugar (glucose) in the blood). Continued record review for Resident R115 revealed that the resident was admitted to the hospital on [DATE], with hypoglycemia (when the level of sugar in your blood drops below the healthy range). A review of the list of residents sent to the Ombudsman for facility initiated emergency discharged for July or August 2025 did not reveal Resident R115 was included in this notification. An interview on September 25, 2025, at 12:40 p.m. with the Administrator, confirmed that, the Long-Term Care Ombudsman was not informed of these particular transfers and discharges for these four residents. 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, review of clinical records, and review of facility policy, it was determined that the facility did not ensure to develop a care plan related to resident's right-hand contracture for one of six residents reviewed (Resident R3)Findings include:Review of facility policy ?Care Plans, Comprehensive Person-Centered,' revised March 2022, indicates that 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: e. reflects currently recognized standards of practice for problem areas and conditions.Review of Resident R3's clinical record revealed medical diagnosis of contracture of right hand.Review of nursing notes, dated June 2, 2025, indicates patient with a history of spasticity in the right handReview of nursing note, dated July 7, 2025, indicates Resident R3 had contracture, right wrist.Observations of Resident R3 on Monday, September 22, 2025, revealed the resident had a right hand/ wrist contracture.Review of resident's care plan revealed no evidence that a care plan was developed to address Resident R3's right hand/wrist contractures.28 Pa Code 211.12(d)(5) Nursing services		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on review of resident council minutes and facility policy, interviews with the resident council, and the preferences of the residents, determined that the facility failed to provide an ongoing program to support residents choice of daily fresh air activities, and failed to facilitate a facility-sponsored trip as a group activities, to support the residents' interests in interacting with the outside community for nine of nine residents interviewed (Resident R18, R38, R39, R52, R68, R71, R77, R78, and R79). Review of facility policy 'Activity Evaluation,' revised February 2023, indicates that in order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities. Further review of policy indicates that 6. The activity evaluation is used to develop individual activities care plan (separate from or as part of the comprehensive care plan) that will allow the resident to participate in activities of his/her choice and interest. Interview with facility's activities director, Employee E4, on Monday, September 22, 2025, at 10:00 am, revealed that residents were escorted outside to gazebo for fresh air break on Tuesday and Thursdays, at either at 2:00 pm or 3:00 pm - depending on the weather. Observations of first floor and second floor units revealed no evidence of posted schedule for fresh air break. Interview with Resident R77 on Monday, September 22, 2025, at 9:45 am, revealed that she is allowed for fresh air break only if it's during scheduled smoking times - on patio of second floor dining room. Interview with Resident R18, on Monday, September 22, 2025, at 10:40 am, revealed that he is not offered an option for fresh air break. On September 24, 2025, at 10:15 a.m. during an interview with nine alert and oriented residents (Resident R18, R38, R39, R52, R68, R71, R77, R78, and R79) from the facility's Resident council group, the residents revealed the non-smokers were not offered by staff to go outside for daily fresh air but the residents who smoke were offered cigarette breaks, four times a day. Review of the previous resident council minutes from May 2025 to September 2025 revealed the residents were requesting outings and more time outdoors. Further review of the council minutes revealed on June 11, 2025, the response from the activity department discussed Several fundraisers to cut cost of transportation. During the July 9, 2025 meeting indicated that the old business previously discussed were resolved, and the activity department informed the residents they were starting, Monthly outings starting in August 2025. Further interview revealed the residents stated there were no scheduled outings in September and no further conversation regarding future day trips and/or fundraisers. These concerns were confirmed with the Director of Nursing on September 24, 2025, at 1:25 p.m. 28 Pa Code 201.18(b)(3) Management		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and staff interview, it was determined that the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with professional standards, and to discard expired medications in accordance with professional standards, for one of one medication storage room. (Second Floor).Findings include:Observation of the Medication Storage Room of the Second Floor, on September 24, 2025, at 2:04 p.m., revealed the temperature of the medication storage refrigerator was 54 degrees Fahrenheit. The refrigerator was cluttered with various items, and eight Influenza vaccine (syringes form) with expiration date June 30, 2025.Interview with a Roistered Nurse, Employee E14, at the time of the finding, confirmed that the Influenza vaccine (syringes form) should have been discarded.28 Pa Code 211.9(g)(h) Pharmacy services28 Pa Code 211.12(c) Nursing services		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of clinical records, observations, and resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 32 residents reviewed (Resident R83). Findings include: Review of Resident R83's physician order dated June 20, 2024, revealed an order for Prozac Oral Capsule (Fluoxetine HCl), give 20 milligrams (mg) by mouth one time a day related to Major Depressive Disorder, Anxiety Disorder; give with 10mg to equal 30 mg. On September 23, 2025, at 9:55 a.m., during review of medication administration, it was observed that a Licensed Practical Nurse, Employee E15, administered to Resident R83 one tablet of Fluoxetine 20 mg capsule. On September 23, 2025, at 10:01 a.m., during an interview, Employee E15, clarified that Resident R83 was on gradual dose reduction for Prozac Oral Capsule (Fluoxetine HCl); hence the actual dosage of Prozac Oral Capsule (Fluoxetine HCl) to administer to R83 was only 20 mg by mouth; but the same was not displayed in the electronic physician order; at the time of the finding. An interview with the Director of Nursing, on September 23, 2025, at 1:21p.m., confirmed the finding. 28 Pa Code: 211.5(b)(i) Clinical Records		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on review of clinical records and interview with staff, it was determined that facility did not ensure to provide pertinent information regarding the immunizations to the resident or the resident's representative such as the benefits and potential side effects of the influenza and, as applicable, the pneumococcal immunization for 18 out of 100 residents reviewed (Resident R66, R105, R32, R15, R118, R54, R102, R55, R51, R100, R93, R109, R62, R83, R69, R94, R99, R76)Findings include:Review of facility policy ?Pneumococcal Vaccine,' revised March 2023, indicates that before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record.Review of facility policy ?Influenza Vaccine.' Revised August 29, 2025, indicates that prior to vaccination , the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's /employee's medical record.Review of Resident R66's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R105's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R32's clinical record revealed pneumococcal vaccine was administered on January 26, 2024; there was no documented evidence that education was provided.Review of Resident R15's clinical record revealed pneumococcal vaccine was administered on October 23, 2024; there was no documented evidence that education was provided.Review of Resident R15's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R118's clinical record revealed pneumococcal vaccine was administered on October 23, 2024; there was no documented evidence that education was provided.Review of Resident R54's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R102's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R55's clinical record revealed influenza vaccine was administered on October 1, 2024; there was no documented evidence that education was provided.Review of Resident R51's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R51's clinical record revealed pneumococcal vaccine was administered on October 23, 2024; there was no documented evidence that education was provided.Review of Resident R100's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R100's clinical record revealed pneumococcal vaccine was administered on October 23, 2024; there was no documented evidence that education was provided.Review of Resident R93's clinical record revealed pneumococcal vaccine was administered on October 22, 2024; there was no documented evidence that education was provided.Review of Resident R109's clinical record revealed pneumococcal vaccine was administered on October 25, 2024; there was no documented evidence that education was provided.Review of Resident R62's clinical record revealed pneumococcal vaccine was administered on October 23, 2024; there was no documented evidence that education was provided.Review of Resident R83's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R69's clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R94s clinical record revealed influenza vaccine was administered on October 7, 2024; there was no documented evidence that education was provided.Review of Resident R99's clinical record revealed pneumococcal vaccine was (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered on October 23, 2024; there was no documented evidence that education was provided.Review of Resident R76's clinical record revealed pneumococcal vaccine was administered on October 22, 2024; there was no documented evidence that education was provided.Interview with facility's director of nursing, employee E1, on Wednesday, September 24, 2025, at 11:20 am, confirmed that education was not provided prior to administering vaccinations.28 Pa Code 201.14(a) Responsibility of licensee28 Pa Code 201.18(b)(1) management28 Pa Code 211.15(f) clinical records		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on review of clinical records and interview with staff, it was determined that facility did not ensure to provide pertinent information regarding the immunizations to the resident or the resident's representative such as the benefits and potential side effects of the covid-19 immunizations for two out of 100 residents reviewed (Resident R116 and R29)Findings include:Review of Resident R116's clinical record indicates covid-19 immunization was administered on November 8, 2024; there was no documented evidence that education was provided.Review of Resident R29's clinical record indicates covid-19 immunization was administered on December 3, 2024; there was no documented evidence that education was provided.Interview with facility's director of nursing, employee E1, on Wednesday, September 24, 2025, at 11:20 am, confirmed that education was not provided prior to administering vaccinations.28 Pa Code 201.14(a) Responsibility of licensee28 Pa Code 201.18(b)(1) Management28 Pa Code 211.15(f) Clinical records		

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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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Ivory Wellness Center		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)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and employee interviews, it was determined that the facility failed to maintain the dish washing machine in the main kitchen and the med storage refrigerator on the second-floor medication room in an operating condition. Findings include: Observation on September 23, 2025, at 1:30 p.m. during a follow-up tour of the dietary department with the Food Service Director (FSD), Employee E3, revealed that the dish washing machine had a final rinse temperature of 120 degrees. When asked about this the FSD indicated that the booster heater had recently been worked on but was still waiting for parts and they were to be using it as a low temperature chemical sanitizing machine. When asked to check the chlorine ppm, the FSD got no reading on his test strips. It was noted that the plastic tubing was laying on the floor next to a closed gallon jug of household bleach. The FSD removed the cap and put the tubing into the jug of bleach and ran the machine for several minutes. After allowing the machine to run for a few minutes with empty dish racks going through he tested the chlorine level again and still got no reading on the test strips. The FSD stated that they were waiting for the technician from the equipment and chemical company who was in route to check the machine. At 2:05 pm the technician, Employee E13 arrived and adjusted the sanitizer pump and got a mild reading of about 50 ppm, the minimum level of chlorine for sanitizing dishware. The technician confirmed that the facility should not be using household bleach, but rather the chlorine sanitizer designed for commercial dish washing machines. Interview with the Maintenance Director, Employee E12 on September 23, 2025, at 1:45 p.m. confirmed that he was aware that the facility was waiting for parts for the dish washing machine and that they should be using an approved sanitizer which they would borrow from their sister facility across the street. Interview with the FSD conducted on September 23, 2025, at 2:15 p.m. confirmed the above findings and revealed that he did not know why the sanitizer was not hooked up and operating and that they had not checked the chloring level prior to washing the lunch dishes. 28 Pa Code 201.14(a) Responsibility of licensee		