STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395555	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pennsburg Manor	530 MacOby Street Pennsburg, PA 18073

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840 Based on facility policy review, clinical record review, observation, and interview, it was determined that the facility failed to provide care and services in a manner respectful of each resident's dignity to promote the quality of life for one of 26 sampled residents. (Resident 257) Findings include: Review of the facility policy entitled, Patient Security Bracelet, last reviewed July 1, 2024, revealed that residents were evaluated for the need of a wandering security bracelet to serve as a safety measure to prevent elopement (unauthorized departure from the facility) and wandering in unsafe areas of the center. Clinical record review revealed that Resident 257 was admitted to the facility on [DATE], with diagnoses that included pyogenic arthritis of the right knee joint (inflammation in one or more of the joints caused by an infection) and spinal stenosis (narrowing of the space in the spine). Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was not cognitively impaired, required supervision with ambulation and transfers, and did not exhibit wandering behavior. Review of Resident 257's Elopement Evaluation dated April 20, 2025, revealed that the resident was not ask risk for elopement. Further review revealed another Elopement Evaluation dated April 30, 2025, stating that the resident had expressed a desire to go home and that the resident wandered. However, there was no evidence in the clinical record to support that Resident 257 had wandered or attempted to elope from the facility. Observation on May 4, 2025, at 12:19 p.m., revealed Resident 257 sitting up in bed with a wandering security bracelet on the left ankle. In an interview at that time, Resident 257 stated, This band is an insult to my intelligence; where am I going to go? I am here for antibiotics and physical therapy. I just want to go outside when it's nice and they won't allow it. There was no evidence in the clinical record to support that the wandering security bracelet was discussed with the resident or that the resident was agreeable to its use. In an interview on May 6, 2025, at 9:35 a.m., the Administrator stated that the resident should not have had the wandering security bracelet. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to assess bladder incontinence and provide treatment and services to restore bladder function as much as possible for one of four sampled residents with urinary incontinence. (Resident 97) Findings include: Review of the policy entitled, Continence Management, last reviewed January 2025, revealed that residents were to be assessed for the need for a continence management program as part of the nursing assessment process. A urinary incontinence assessment was to be completed upon admission. The purpose was to provide appropriate treatment and services for residents with urinary incontinence to minimize urinary tract infections and restore continence to the extent possible. The facility was to develop individualized interventions and a plan of care based on information from assessments and voiding records/documentation. Clinical record review revealed that Resident 97 was admitted [DATE], and had diagnoses of encephalopathy, disturbance of the brain, and weakness. The Minimum Data Set assessment dated [DATE], indicated that the resident was only slightly cognitively impaired, was frequently incontinent of bowel and bladder, and was not on a toileting program. The assessment also indicated that the problem of urinary incontinence was to be addressed in the care plan. On March 6, 2025, a nurse documented that the resident was incontinent of urine and used adult briefs. There was no documented evidence that a urinary incontinence assessment was completed upon admission in order to assess and provide treatment and services to the resident for urinary incontinence in order to restore bladder continence to the extent possible. In addition, there was no care plan developed with specific interventions to address/restore urinary incontinence. In an interview on May 6, 2025, at 11:00 a.m., the Administrator stated that the staff had not completed a urinary incontinence assessment nor developed and implemented specific care planned interventions to address and attempt to restore bladder function as per facility policy. 28 Pa.Code 211.12(d)(1)(5) Nursing services.

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(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. 17709 Based on observation, it was determined that the facility failed to maintain sanitary conditions in the dietary department. Findings include: An environmental tour of the food service department on May 4, 2025, at 9:06 a.m., revealed the following: There were five stained ceiling tiles above a table that contained a large coffee maker. There were areas on the back splash of the stove and around the burners that were stained with a blackish/brown substance. The bottom of the convection oven was dirty with burnt crumbs. The doors on the inside of the convection oven were covered with grease and burnt substances. 28 Pa.Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.