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	03/26/2026

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 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** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to restore continence to the extent possible for one of four sampled residents with urinary incontinence. (Resident 87) Findings include: Review of the facility policy entitled, Continence Management, last revised July 15, 2025, revealed that residents were to be assessed for continence management. Residents who were incontinent of bladder were to receive appropriate treatment for prevention of incontinence associated dermatitis and to restore bladder continence to the extent possible. A nursing assessment was to be conducted to determine the type of incontinence, voiding patterns, physical and cognitive functional abilities, and any pertinent diagnoses. The facility was to develop individualized interventions and a plan of care based on information from assessments and voiding records. Clinical record review revealed that Resident 87 had diagnoses that included difficulty walking and history of a malignant neoplasm of the uterus. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert and oriented and was frequently incontinent of urine. A review of the care plan revealed that the resident required assistance from staff for toileting due to limited mobility. There were no interventions to attempt to restore bladder continence. Review of nursing documentation revealed that for the last 30 days, the resident was noted to be incontinent of urine greater then 50 times throughout the month. There was no documented evidence that staff had completed a nursing assessment to determine the type of incontinence, voiding patterns, and any pertinent diagnoses that may affect bladder continence. In addition, there was no documented evidence that the facility developed a care plan with interventions to provide treatment and services to attempt to restore bladder continence. In an interview on March 26, 2026, at 9:35 a.m., the Director of Nursing confirmed that the resident had not been assessed for continence management and a care plan was not developed with interventions to attempt to restore as much bladder function as possible per facility policy. CFR 483.25(e)(2) IncontinencePreviously cited 5/6/25 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

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	03/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to implement Enhanced Barrier Precautions (EBPs) and the use of personal protective equipment (PPE) to prevent the spread of infection for two of 21 sampled residents. (Residents 2 and 11)Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed November 14, 2025, revealed that, in addition to standard precautions, Enhanced Barrier Precautions (EBPs) would be used (when Contact precautions do not otherwise apply) for novel or targeted Multi-Drug-Resistant-Organisms (MDROs). Staff was to wear a gown and gloves during high contact resident care activities such as dressing, transferring from the bed to chair and back, and changing linens to prevent infections even when exposure to body fluids and blood was not anticipated. EBPs were used to help reduce the transmission of MDROs by requiring the use of gowns and gloves during specific high contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of acquiring an MDRO. Residents at risk include but are not limited to those with feeding tubes, indwelling urinary catheters, central vascular lines, tracheostomy tubes, and wounds. Standard precautions such as hand hygiene always applied and precautions included the use of protective gowns and gloves during high-risk activities. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included cellulitis (a spreading skin infection, most commonly of the lower leg caused by bacteria entering through a break in the skin) of the right and left lower limbs , rhabdomyolysis (the breakdown of skeletal muscle tissue leading to the release of myoglobin and other harmful substances into the bloodstream), sepsis due to Methicillin Resistant Staphylococcus Aureus (MRSA), and diabetes mellitus. The care plan revealed that Resident 2 required Enhanced Barrier Precautions and interventions included that staff wear gloves and gowns during close contact interactions, including bed transfers. Observation on March 24, 2026, at 12:40 p.m., revealed that a nurse aide (NA 1) collected a soiled gown and bed linens from Resident 2 without the use of a gown or gloves, carried them unbagged to the soiled closet, then obtained a mechanical lift for the resident. Staff did not wash or sanitize her hands before obtaining the lift for the resident. NA 1 entered Resident 2's room to transfer Resident 2 with a registered nurse (RN 1) and the mechanical device from the bed. Neither RN 1 nor and NA 1 wore a gown and NA 1 did not wear gloves to perform the transfer with Resident 2. At the time of the observation, RN 1 confirmed that the Resident 2 had an open wound on his right leg. There was an EBP sign posted on his door. Clinical record review revealed that Resident 11 was admitted to the facility on [DATE], with diagnoses that included hypothyroidism (an overactive thyroid gland), dementia, and pain. Review of the clinical record revealed that Resident 11 had a pressure ulcer on the left heel and was identified on the care plan as at risk for MDRO colonization/infection due to the left heel wound. Review of the Minimum Data Set assessment dated [DATE], revealed that Resident 11 had one unhealed pressure ulcer. On March 25, 2026, at 8:33 a.m., a sign was observed on Resident 11's door indicating EBPs were required for care. At that time, RN 2, entered the resident's room and proceeded to assist the resident with dressing. RN 2 did not wear a gown to perform care. On March 26, 2026, at 1:30 p.m., the Director of Nursing confirmed that the above identified staff did not follow the facility infection control policy. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.