

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Sanatoga Center		STREET ADDRESS, CITY, STATE, ZIP CODE 225 Evergreen Road Pottstown, PA 19464	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45244</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for two of 25 sampled residents. (Residents 23, 111)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 23 had diagnoses that included hypertension (high blood pressure). A physician's order dated December 25, 2023, directed staff to administer a medication (carvedilol) two times a day for hypertension. Staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 110 millimeters of mercury (mmHg). Review of Resident 23's medication administration records revealed that staff administered the medication four times in July 2024 and three times in August 2024 outside of the ordered parameters.</p> <p>In an interview on August 16, 2024, at 10:30 a.m., the Director of Nursing confirmed the medication should not have been administered when the SBP was less than 110 mmHg per physician's order.</p> <p>Clinical record review revealed Resident 111 was admitted to the facility on [DATE], with diagnoses that included epilepsy. On July 24, 2024, the physician ordered for the resident to receive phenobarbital (an anticonvulsant medication) 64.8 milligrams at bedtime. There was no documented evidence that Resident 111 received the phenobarbital on July 25, 2024.</p> <p>In an interview on August 16, 2024, at 10:40 a.m., the Director of Nursing confirmed that Resident 111 did not receive the medication on July 25, 2024.</p> <p>CFR 483.25 Quality of Care</p> <p>Previously cited 8/18/23 and 5/28/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</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 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>45125</p> <p>Based on staff interview and observation, it was determined that the facility failed to properly store food and maintain sanitary conditions in the dietary department, on one of two unit kitchens (Bistro 1), and on one of two unit pantries (1st Floor).</p> <p>Findings include:</p> <p>In an interview on August 13, 2024, at 9:50 a.m., Dietary Manager (DM) 1 stated that all opened food items were to be labeled with a date. In an interview on August 16, 2024, at 10:35 a.m., the Administrator stated that refrigerated foods were to be discarded after seven days and that foods in the unit pantry were to have the resident's name and date written on them by staff.</p> <p>Observations of the main kitchen on August 13, 2024, at 9:50 a.m., revealed the following:</p> <p>In dry storage, there was a bottle of syrup removed from the original packaging that was not dated. In the walk-in cooler, there was an opened package of lunch meat that was not dated. In the snack reach-in cooler, there was a box of raw pork that was dated August 1, 2024. In the freezer truck, there were three opened garden burgers that were not dated. There were two boxes of opened hamburger buns with ice on top of them. In the food preparation area, the can opener piercer had thick dried food debris on it.</p> <p>In the Bistro 1 unit kitchen, the three drawers under the steam table had multiple areas of dried, sticky food debris on the front and edge. In the refrigerator, there was a package of turkey lunch meat and a pan of meat salad that were not dated. The freezer had dried food particles along the bottom. The outside of the refrigerator had multiple areas of dried food debris and several areas of rust along the door edges.</p> <p>In an interview on August 13, 2024, at 10:30 a.m., DM1 confirmed the previously mentioned food items should have been dated.</p> <p>Observation of the 1st floor unit pantry on August 14, 2024, at 1:06 p.m., revealed in the freezer, there were five bottles of water with no name or date on them. In the refrigerator, there was a salad with a use-by date of August 8, 2024, four opened bottles of tea, lemonade, two sports drinks, a bottle of juice, and a cup of ice tea. These items were not labeled with a resident's name or date. There were two cartons of chocolate milk with an expiration date of August 9, 2024. There were two dished containers of strawberries and pasta salad that were not dated. In the refrigerator drawer, there were two containers of a dished food with red sauce that were not labeled with a resident's name or date.</p> <p>In an interview on August 14, 2024, at 1:10 p.m., Registered Nurse (RN) 1, confirmed the unit pantry refrigerator was to be used for resident food items.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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