

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: 395904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2025
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on two of two nursing units. (First and Second floors)Findings include:Observations on July 22, 2025, from 9:30 a.m. through at 2:30 p.m. and July 25, 2025, from 8:00 a.m. through 12:00 p.m. revealed the following:The wall between the door and dresser in room [ROOM NUMBER] was damaged. The wall beside the resident's bed was streaked with dried liquid in room [ROOM NUMBER]-A.room [ROOM NUMBER]-A had scuffed and peeling wallpaper, and a broken handle on the resident's dresser.The wall beside the resident's bed was streaked with dried liquid in room [ROOM NUMBER]-A.The wall beneath the towel rack in the bathroom in room [ROOM NUMBER] was damaged.The wall was damaged at the baseboard at the closet in room [ROOM NUMBER].room [ROOM NUMBER] A and B bedside tables had chipped wood on the tops. The second floor bathing room shower stall on the right side of the room had a thick black substance on the floor and molding.		

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for four of 22 sampled residents. (Residents 5, 8, 9, and 10) Findings include: Clinical record review revealed that Resident 5 had diagnoses that included diabetes mellitus and dysphagia (difficulty swallowing.) A physician's order dated July 11, 2025, directed staff to weigh Resident 5 two times per week, on Tuesdays and Fridays, for four weeks. Review of Resident 5's medication administration record (MAR) revealed that staff failed to weigh the resident as ordered on July 11, 18, and 22, 2025. Clinical record review revealed that Resident 8 had diagnoses that included post traumatic seizures, chronic systolic (congestive) heart failure, and diabetes mellitus. A physician's order dated January 31, 2025, directed staff to weigh the resident every Monday, Wednesday, and Friday. Review of Resident 8's MARs revealed that staff failed to weigh the resident as ordered five times in April 2025, once in May 2025, and once in June 2025. Clinical record review revealed that Resident 9 had diagnoses that included hypertensive chronic kidney disease and diabetes mellitus. A physician's order dated July 7, 2025, directed staff to weigh Resident 9 every Monday for four weeks. Review of Resident 9's MAR revealed that staff failed to weigh the resident as ordered on July 21, 2025. Clinical record review revealed that Resident 10 had diagnoses that included congestive heart failure and chronic kidney disease. A physician's order dated June 26, 2025, directed staff to administer a medication (metoprolol succinate) two times a day for hypertension. The medication was to be held if the resident's systolic blood pressure (SBP) was lower than 110 millimeters of mercury (mm/Hg) or if the resident's heart rate was less than 60 beats per minute. Review of Resident 10's MARs revealed that staff administered the medication two times in July 2025, when the resident's systolic blood pressure was below 110, and staff administered the medication once and held it once in July 2025 without assessing the blood pressure or heart rate. In interviews on July 25, 2025, at 10:00 a.m. and 11:23 a.m., the Director of Nursing confirmed that weights for residents 5, 8, and 9 had not been completed and medications were administered outside of the established parameters for Resident 10 on two occasions and administered or held without documented blood pressure on two occasions. CFR 483.25 Quality of Care Previously cited 8/16/2428 Pa. Code 211.12(d)(1)(5) Nursing services.		

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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 that medications with the potential for abuse (controlled substances) were secured in a locked, permanently affixed compartment at all times in one of two medication rooms. (Second Floor medication room) Findings include: Observation on July 25, 2025, at 11:50 a.m., revealed that the Second Floor medication room refrigerator contained four two-milligram vials of a Schedule IV anti-anxiety medication (lorazepam). The vials of medication were in a locked box, but the box was easily removable and not permanently affixed to the refrigerator. The refrigerator was not locked. In an interview on July 25, 2025, at 2:20 p.m., the Director of Nursing stated that the controlled medication storage box should have been permanently affixed to the refrigerator. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0677 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff and resident interviews, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for three of 22 sampled residents. (Residents 7, 9, and 116) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included polyneuropathy, cognitive communication deficit, and congestive heart failure. A review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 7 was alert and oriented and required moderate assistance with personal hygiene. Review of the care plan dated May 24, 2025, revealed that the resident required assistance with activities of daily living (ADLs) including grooming and bathing. On July 23, 2025, at 11:43 a.m., the resident was observed in his wheelchair. His fingernails were long and dirty. The resident stated that his fingernails needed to be cut. On July 24, 2025, at 12:04 p.m., the resident was again observed in his wheelchair. His fingernails remained long and dirty. Clinical record review revealed that Resident 9 had diagnoses that included polyneuropathy, shoulder pain, and muscle weakness. A review of the MDS assessment dated [DATE], revealed that Resident 9 was alert and oriented and required moderate assistance with personal hygiene. Review of the care plan dated July 9, 2025, revealed that the resident required assistance with ADLs including grooming and bathing. On July 22, 2025, at 12:37 p.m., July 23, 2025, at 8:50 a.m., and on July 24, 2025, at 9:57 a.m. and 12:45 p.m., the resident was observed in his wheelchair. His fingernails were long and dirty. In an interview on July 25, 2025, at 9:57 a.m., Resident 9 stated he prefers his nails short, that staff had not offered to trim them before today, and that he had trouble cutting them himself without injury due to his numbness, pain, and weakness in his upper extremities. Clinical record review revealed that Resident 116 had diagnoses that included Parkinson's disease and diabetes. A review of the MDS assessment dated [DATE], revealed that Resident 116 was alert with some confusion and required moderate assistance with personal hygiene. Review of the care plan dated July 2, 2025, revealed that the resident required ADLs including grooming and bathing. On July 22, 2025, at 12:57 p.m., July 23, 2025, at 12:40 p.m., and July 24, 2025, at 12:18 p.m., the resident was observed in his wheelchair. His fingernails were long and dirty. In an interview on July 24, 2025, at 12:14 p.m., the resident stated that he prefers his nails short, he wanted his fingernails cut, but he needed assistance. In interviews on July 25, 2025, at 10:00 a.m. and 10:16 a.m., the Director of Nursing confirmed that the residents' fingernails should have been trimmed when residents were bathed and as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		