STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395904	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanatoga Center	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 assess a resident's capability to self-administer medications for two of 24 sampled residents. (Residents 54 and 118) Findings include: Review of the facility policy entitled, Medications: Self-Administration, last reviewed May 15, 2026, revealed that a resident may exercise the right to self-administer medications when determined that this practice was safe. It was the responsibility of the Interdisciplinary Team to determine the following issues with regards to resident self-administration of medications: resident safety to self-administer medications, location of medication administration, determine who would be responsible for storage, and documentation of medication administration. If the resident indicated a desire to self-administer his or her medications, the Interdisciplinary Team would complete the Self-Administration of Medications UDA (User Defined Assessment) to determine the resident's ability to safely self-administer medications. The Care Plan would document interventions to support self-administration of medications by the residents. Clinical record review revealed that Resident 54 was admitted to the facility on [DATE], and had diagnoses that included diabetes, emphysema (a chronic lung condition that causes shortness of breath due to damage to the air sacs of the lungs), and chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe). Review of the Minimum Data Set (MDS) assessment, dated April 2, 2026, revealed that Resident 54 was alert and oriented. Observation on June 23, 2026, at 11:13 a.m., revealed a prescribed inhaler was on the resident's bedside table. In an interview on June 23, 2026, at 11:13 a.m., the resident stated that he was permitted to administer the medication by himself. There was no documentation to support that the resident had a physician's order to self-administer medications or that the interdisciplinary team had assessed the resident to self-administer medications. Clinical record review revealed that Resident 118 was admitted to the facility on [DATE], and had diagnoses that included colon cancer, heart disease, and kidney disease. Review of the MDS assessment, dated May 18, 2026, revealed that Resident 118 was alert and oriented. Observations of the resident's tray table on June 23, 2026, at 11:12 a.m., June 24, 2026, at 9:01 a.m., and on June 26, 2026, at 11:35 a.m., revealed an open tube of prescription silver sulfadiazine topical cream. In an interview on June 24, 2026, at 1:29 p.m., the resident stated that he was permitted to administer the medication by himself. There was no documentation to support that the resident had been assessed to self-administer medications. In an interview on June 26, 2026, at 11:15 a.m., the Nursing Home Administrator confirmed that (continued on next page)

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
	395904	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanatoga Center	225 Evergreen Road Pottstown, PA 19464

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents 54 and 118 did not have a physician's order to self-administer medications, and the residents were not assessed to self-administer the medications. 28 Pa. Code 211.12(d)(1)(3)(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 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 two of 24 sampled residents. (Residents 3, 82) Findings include: Clinical record review revealed that Resident 3 had diagnoses that included chronic heart failure and diabetes. A physician's order dated June 6, 2026, directed staff to administer a blood pressure medication (midodrine hydrochloride) three times a day for orthostatic hypotension. Staff were not to give the medication if Resident 3's systolic blood pressure (the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 120 millimeters of mercury (mm Hg). A physician's order dated June 20, 2026, directed staff to weigh Resident 3 daily and to notify the physician if there was a weight gain greater than five pounds in one week or two pounds in one day. Review of Resident 3's June 2026 Medication Administration Record (MAR) and Task Administration Record revealed that staff administered the midodrine hydrochloride three times when the systolic blood pressure was greater than 120 mm Hg and failed to obtain a daily weight on June 21 and 22, 2026. Clinical record review revealed that Resident 82 had diagnoses that included dementia and diabetes. A physician's order dated June 21, 2021, directed staff to administer a Dulcolax suppository as needed for constipation if no bowel movement in four days. Review of bowel movement tracking documentation for Resident 82 revealed that there were no bowel movements recorded from June 13, 2026, through June 17, 2026. Review of the MAR for June 2026 revealed that the resident was not provided the Dulcolax suppository as ordered. In an interview conducted on June 26, 2026, at 1:33 p.m., the Administrator confirmed that staff did not follow the physician's orders. CFR 483.25 Quality of Care Previously cited 7/25/25 28 Pa. Code 211.12(d)(5) Nursing services.