

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>POTTSTOWN SKILLED NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>724 NORTH CHARLOTTE STREET POTTSTOWN, PA 19464</b>		
STATE LICENSE NUMBER: <b>380402</b>				
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F 0000	INITIAL COMMENT	F 0000		
F 0558 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on April 10, 2025, it was determined that Pottstown Skilled Nursing and Rehabilitation Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558  SS=D	Continued from page 1  483.10(e)(3) Reasonable Accommodations Needs/Preferences  §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.  This REQUIREMENT is not met as evidenced by:	F 0558	Part 1. Resident #13 was provided with a hand bell as care planned.  Part 2. Residents with/without psychiatric diagnosis were audited to ensure care planned interventions for a call light or alternative communication device is in place at all times. Facility audit completed to ensure each resident has a call bell clip to secure the call bell within easy access of the resident.  Part 3. Facility staff education on ensuring residents with/without psychiatric dx are provided with a call light or alternative communication devices as care planned and that call bells are accessible.  Part 4. Residents with/without a psychiatric dx will be audited to ensure care planned interventions for call bells are in place. Auditing will occur weekly X 4 weeks, bi-weekly X 4 weeks and monthly X 1 month. Audit results will be reviewed monthly at QAPI.	Completion Date: <b>05/13/2025</b> Status: <b>APPROVED</b> Date: <b>04/29/2025</b>

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F 0558  SS=D	Continued from page 2	F 0558	Part 5. Date of compliance is May 13, 2025	

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F 0558  SS=D	Continued from page 3  Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to ensure that call bells were accessible for one of 28 sampled residents. (Resident 13)  Findings include:  Clinical record review revealed that Resident 13 had diagnoses that included hemiplegia and hemiparesis (paralysis on one side of the body), contracture of muscle (stiffness in the connective tissues of the body), and muscle weakness. The Minimum Data Set assessment, dated February 7, 2025, revealed Resident 13 was able to communicate needs to staff and required extensive assistance from staff for mobility and activities of daily living such as toilet use, grooming, and hygiene. Review of the care plan revealed that the resident had a self-care deficit due to physical limitations and contractures, and was a risk for behavioral symptoms. An intervention was for staff to provide Resident 13 with a handbell to call for assistance. On April 8, 2025, at 10:00 a.m.,	F 0558		

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F 0558  SS=D	Continued from page 4  Resident 13 was observed in bed without a handbell. In an interview at that time, Resident 13 stated that she could not find her handbell. Resident 13 was observed again at 11:40 a.m. and at 1:30 p.m., in bed without a handbell.  In an interview on April 10, 2025, at 9:10 a.m., the Director of Nursing confirmed that the handbell should have been provided for Resident 13 to call for assistance.  28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0558		
F 0575  SS=C		F 0575		

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F 0575  SS=C	Continued from page 5  483.10(g)(5)(i)(ii) Required Postings  §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.  This REQUIREMENT is not met as evidenced by:	F 0575	Part 1. The required postings were established and made available for all on 4/09/2025.  Part 2 - The required correction was made immediately upon notification. No other review of related infraction is indicated.  Part 3. The NHA was educated on the regulation for required postings to be made available for all to reference.  Part 4. Required postings will be audited for accessibility/placement weekly X 4 weeks, bi-weekly X 4 weeks, and monthly X 1 month. Audit results will be reviewed at QAPI.  Part 5. Date of compliance is May 13, 2025.	Completion Date: <b>05/13/2025</b> Status: <b>APPROVED</b> Date: <b>04/25/2025</b>

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F 0575  SS=C	Continued from page 6  Based on observation and interview, it was determined that the facility failed to ensure that information regarding how to contact State agencies and advocacy groups, including a statement that the resident may file a complaint with the State Survey Agency, was accessible to all residents, visitors, and staff.  Findings include:  In a confidential family interview on April 8, 2025, at 10:15 a.m., it was revealed that information regarding how to contact State agencies and advocacy groups, including the State Survey Agency, was not available and posted for all residents, visitors and staff. In addition, observation revealed there was no information posted that included a statement that the resident may file a complaint with the State Survey Agency.  In an interview on April 9, 2025, at 1:30 p.m., the Administrator confirmed that the names and phone numbers of various advocacy groups, including the	F 0575		

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F 0575  SS=C	Continued from page 7  State Survey Agency, was not posted and available to residents, staff, and visitors.  28 Pa. Code 201.29(a)(c.1) Resident rights.	F 0575		
F 0656  SS=D		F 0656		

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F 0656  SS=D	Continued from page 8  483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Part 1. Residents 45 and 77 care plans were updated to include urinary continence. Resident 129 care plan was updated to include bowel incontinence.  Part 2. Like residents with urinary or bowel incontinence have been audited to identify any missing care planned interventions. Any change in condition or newly admitted residents will be reviewed daily during clinical meetings.  Part 3. Nursing staff education on including appropriate interventions for urinary and bowel incontinence and documenting the interventions in the care plan.  Part 4. Residents identified with urinary and bowel incontinence will be audited to ensure appropriate interventions are in place. Auditing will occur weekly X 4 weeks, bi-weekly X 4 weeks and monthly X	Completion Date: <b>05/13/2025</b> Status: <b>APPROVED</b> Date: <b>04/29/2025</b>

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F 0656  SS=D	Continued from page 9  discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.  This REQUIREMENT is not met as evidenced by:	F 0656	1 month. Audit results will be reviewed at QAPI.  Part 5. Date of Compliance is May 13, 2025.	

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F 0656  SS=D	Continued from page 10  Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for two of 28 sampled residents. (Residents 45, 77) In addition, the facility failed to develop and implement interventions to address bowel incontinence in the resident's comprehensive care plan for one of 28 sampled residents. (Resident 129)  Findings include:  Clinical record review revealed that Resident 45 was admitted to the facility on August 31, 2024, and had diagnoses that included diabetes, heart disease, and hypertension (high blood pressure). The Minimum Data Set (MDS) assessment and Care Area Assessment (CAA) summary dated September 10, 2024, noted that the resident's urinary incontinence was to be addressed in the care plan. There was no evidence that interventions to address Resident's 45's urinary incontinence were	F 0656		

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F 0656  SS=D	<p>Continued from page 11</p> <p>included in the current care plan.</p> <p>Clinical record review revealed that Resident 77 was admitted to the facility on November 23, 2024, and had diagnoses that included diabetes, urinary tract infection, and hypertension. The MDS CAA summary dated November 27, 2024, noted that the resident's urinary incontinence was to be addressed in the care plan. There was no evidence that interventions to address Resident 77's urinary incontinence were included in the current care plan.</p> <p>Clinical record review revealed that Resident 129 was admitted to the facility on December 31, 2024, and had diagnoses that included diabetes and hypertension. The MDS dated January 7, 2025, indicated the resident was alert, frequently incontinent of bowel, and required assistance from staff for toileting. Review of the resident's care plan revealed the facility did not develop interventions to address Resident's 129's bowel incontinence.</p> <p>In an interview on April 10, 2025, at 9:10 a.m., the</p>	F 0656		

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F 0656  SS=D	Continued from page 12  Director of Nursing confirmed there was no documented evidence that interventions for urinary or bowel incontinence were included in the aforementioned care plans.  28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0656		
F 0689  SS=D		F 0689		

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F 0689  SS=D	Continued from page 13  483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:	F 0689	Part 1. Resident #45 was immediately provided with fall mats as care planned.  Part 2. Like residents with care planned fall mats were audited to ensure the fall mats were properly in place.  Part 3. Facility staff education provided to ensure care planned fall mats are in place as indicated.  Part 4. Residents identified as being care planned to use fall mats will be audited to ensure placement as indicated. Auditing will be completed weekly X 4 weeks, bi-weekly X 4 weeks and monthly X 1 month.  5. Date of compliance is May 13, 2025.	Completion Date: <b>05/13/2025</b> Status: <b>APPROVED</b> Date: <b>04/25/2025</b>

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F 0689  SS=D	Continued from page 14  Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that safety interventions were in place for one of seven sampled residents at risk for falls. (Resident 45)  Clinical record review revealed that Resident 45 had diagnoses that included diabetes, muscle weakness, dizziness, and giddiness (feeling of imbalance and lightheadedness). The Minimum Data Set assessment dated March 10, 2025, revealed that Resident 45 required staff assistance for bed mobility and transfers. Review of progress notes dated March 23, 2025, revealed that the resident was found on the floor in his room by his bed. Review of the care plan identified that the resident was at risk for falls related to impaired mobility. The intervention was for staff to place floor mats on both sides of the bed while the resident was in bed. Multiple observations on April 8 and April 9, 2025, between 9:40 a.m. and 2:00 p.m., revealed Resident 45 was in bed and the floor mats were not in place.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>POTTSTOWN SKILLED NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>380402</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>724 NORTH CHARLOTTE STREET POTTSTOWN, PA 19464</b>		
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F 0689  SS=D	Continued from page 15  In an interview on April 11, 2025, at 9:10 a.m., the Director of Nursing confirmed that the fall mats should have been in place.  28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0689		
F 0690  SS=E		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>
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F 0690  SS=E	Continued from page 16  483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.  §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Part 1. Resident 45 and 77 types of urinary incontinence were identified and interventions were put into place immediately. Resident 129 change of condition bowel incontinence frequency was identified and interventions were put into place immediately.  Part 2. Residents who were admitted or re-admitted to the facility within the last 30 days were reviewed for continence management for incontinence assessment completion. If identified as not having an incontinence assessment in place, it was completed and scheduled as per policy and procedure.  Part 3. Nursing education completed to complete fecal and urinary incontinence assessments upon admission/re-admission, change of condition, quarterly and annually.	Completion Date: <b>05/13/2025</b> Status: <b>APPROVED</b> Date: <b>04/25/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>
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F 0690  SS=E	Continued from page 17  This REQUIREMENT is not met as evidenced by:	F 0690	Part 4. To prevent recurrence, the facility will audit new admissions, re-admissions and those due for quarterly assessments to ensure incontinence assessments are completed. Auditing will be completed weekly X 4 weeks, bi-weekly X 4 weeks and monthly X 1 month. Results will be reviewed monthly at QAPI.  Part 5. Date of compliance is May 13, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>	
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F 0690  SS=E	Continued from page 18  Based on clinical record review, policy review, and staff interview, it was determined that the facility failed to assess bladder incontinence and provide services to restore bladder function as much as possible for three of four sampled residents. (Residents 45, 77, 129)  Findings include:  Review of the facility policy entitled, "Continance Management," last reviewed March 31, 2025, revealed that facility staff was to complete a urinary incontinence assessment and/or bowel incontinence assessment upon admission and re-admission and with a change in condition or change in continence status. Staff would review the pre-admission history, assess the resident's current bladder and bowel elimination problem, and identify causes of incontinence. If there was a change in urinary and/or bowel incontinence, staff would provide appropriate treatment and services to restore continence to the extent possible and implement a toileting diary to determine a resident's voiding	F 0690		

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F 0690  SS=E	Continued from page 19  pattern for assistance in decision-making and development of a toileting program.  Clinical record review revealed that Resident 45 was admitted to the facility with diagnoses that included diabetes, heart disease, and hypertension (high blood pressure). A bowel and urinary incontinence evaluation was completed on September 2, 2024, and indicated that the resident was a candidate for a scheduled toileting program. According to the Minimum Data Set (MDS) assessment, dated March 10, 2025, the resident needed assistance from staff for toileting, was always incontinent of urine, and was not on a toileting program. Review of the current care plan revealed that Resident 45's type of urinary incontinence was not identified and there was no indication that the resident was on a scheduled toileting program. There was no documented evidence that a scheduled toileting program had been implemented.  Clinical record review revealed that Resident 77	F 0690		

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F 0690  SS=E	Continued from page 20  was admitted to the facility on November 23, 2024, and had diagnoses that included diabetes, urinary tract infection, and hypertension. A review of the MDS assessments dated November 24, 2024, and February 19, 2025, revealed that Resident 77 was able to make her needs known and needed assistance from staff for toileting. The assessments further indicated that the resident was frequently incontinent of urine and bowel and was not on a toileting program. Review of the current care plan revealed that Resident 77's type of urinary and bowel incontinence was not identified and there were no specific interventions developed to address Resident 77's urinary and bowel incontinence. There was no documented evidence that a bowel and urinary incontinence evaluation, an assessment to determine the type of incontinence, and an appropriate incontinence program had been completed.  Clinical record review revealed that Resident 129 was admitted to the facility on December 31, 2024, and had diagnoses that included diabetes, kidney	F 0690		

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F 0690  SS=E	Continued from page 21  failure, and hypertension. A review of the MDS assessment January 7, 2025, revealed that Resident 129 was able to make his needs known and needed assistance from staff for toileting. The assessment further indicated that the resident was frequently incontinent of urine and bowel, and was not on a toileting program. A review of the MDS assessment, dated April 7, 2025, revealed that Resident 129's bowel incontinence had changed from frequently to always incontinent of bowel. There was no documentation in the clinical record to support that the resident's urinary and bowel incontinence were assessed by the facility upon admission and upon a change in Resident's 129 incontinence to determine if normal bladder and bowel function could be restored. There was no documented evidence that a toileting diary was completed upon identification of a change in the resident's incontinence status.  In an interview on April 10, 2025, at 9:10 a.m., the Director of Nursing confirmed that there was no documented evidence that Resident 45's toileting	F 0690		

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F 0690  SS=E	Continued from page 22  program was implemented or that Residents 77 and 129's bowel and urinary incontinence was evaluated and addressed after a change in condition.  28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0690		
F 0742  SS=D		F 0742		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>
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F 0742  SS=D	Continued from page 23  483.40(b)(1) Treatment/Srvcs Mental/Psychosocial Concerns  §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;  This REQUIREMENT is not met as evidenced by:	F 0742	Part 1. Resident # 27's care plan was immediately updated to include a newer diagnosis of PTSD. Social Services intervention to include a discussion with the resident to ensure psycho/social components of well being are addressed. The medication recommendations of changing Lexapro to Zoloft was updated in the resident's medication orders.  Part 2. A 30-day look back was completed to review new admissions/re-admissions for PTSD diagnosis and any medication changes. Any new admissions/re-admissions will have a diagnosis and medication review during the morning clinical meeting. Current facility residents with a PTSD diagnosis were identified and reviewed. Care plans were assessed for completion.  Part 3. Facility staff education completed on PTSD care planning requirements and updating	Completion Date: <b>05/13/2025</b> Status: <b>APPROVED</b> Date: <b>04/25/2025</b>

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F 0742  SS=D	Continued from page 24	F 0742	<p>recommended medication changes.</p> <p>Part 4. To prevent recurrence, the facility will audit the diagnosis and medication recommendations of new/re-admissions and appropriately care plan for the diagnosis of PTSD. Auditing will be completed weekly X 4 weeks, Bi-weekly X 4 weeks and monthly X 1 month. Results will be reviewed at QAPI.</p> <p>Part 5. Date of compliance is May 13, 2025.</p>	

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F 0742  SS=D	Continued from page 25  Based on clinical record review and staff interview, it was determined that the facility failed to provide appropriate services and treatment in a timely manner for one of four sampled residents who exhibited behavioral and mood symptoms. (Resident 27)  Findings include:  Clinical record review revealed that Resident 27 had diagnoses that included congestive heart failure, schizoaffective disorder, and auditory hallucinations. The Minimum Data Set assessment dated February 7, 2025, indicated that the resident was alert and oriented, had mood issues that included feeling down, had trouble falling asleep, was tired, and had bad feelings about herself. The assessment also indicated that she had a diagnosis of Post-Traumatic Stress Disorder (PTSD) and was prescribed antidepressant, antianxiety, and antipsychotic medications.  Review of a psychiatric consultation report dated	F 0742		

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F 0742  SS=D	<p>Continued from page 26</p> <p>April 3, 2025, revealed that the resident was being treated for an increase in depressive and anxiety symptoms. There was a recommendation made to discontinue the current physician ordered antidepressant (Lexapro) and to order a different antidepressant (Zoloft) to be administered every day. Review of the current Medication Administration Record for March 2025, revealed that as of April 9, 2025, the resident was still receiving the Lexapro and that the Zoloft recommendation had not been reviewed and/or ordered by the physician.</p> <p>In addition, there was no care plan developed with a problem area and specific interventions to address the diagnosis and condition of PTSD.</p> <p>In an interview on April 10, 2025, at 11:45 a.m., the Director of Nursing stated that the recommendation for the medication change had not been done timely and that there had been no care plan developed to address the PTSD diagnosis for this resident.</p>	F 0742		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>
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F 0742  SS=D	Continued from page 27  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0742		
F 0761  SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 0761	Part 1. The first floor medical room refrigerator was repaired to have a secured lock.  Part 2. Facility medical room refrigerators were inspected to ensure each refrigerator had a functioning locked compartment.  Part 3. Staff education completed regarding the locking of the refrigerated narcotic medications.  Part 4. To prevent recurrence, unit med room refrigerators will be audited to ensure the locking mechanism is functioning properly. Auditing will occur weekly X 4 weeks, bi-weekly X 4 weeks and monthly X 1 month. Audit results will be reviewed monthly at QAPI.  Part 5. Date of compliance is May 13, 2025.	Completion Date: <b>05/13/2025</b> Status: <b>APPROVED</b> Date: <b>04/25/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>
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F 0761  SS=D	Continued from page 28  This REQUIREMENT is not met as evidenced by:	F 0761		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761  SS=D	Continued from page 29  Based on a review of facility policy, 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 four medication rooms. (First Floor)  Finding include:  Review of the facility policy entitled, "Medication Storage Controlled Medication Storage," last reviewed on March 31, 2025, revealed that controlled substances listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 were to be separately locked in permanently affixed compartments, including those controlled substances stored in refrigerators.  Observation on April 9, 2025, at 12:31 p.m., revealed that the first floor medication room refrigerator contained 12 vials and two bottles of a Schedule IV anti-anxiety medication (lorazepam). The medication was not secured in a locked,	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395402</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/10/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>POTTSTOWN SKILLED NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>724 NORTH CHARLOTTE STREET POTTSTOWN, PA 19464</b>		
STATE LICENSE NUMBER: <b>380402</b>					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
F 0761  SS=D	Continued from page 30  permanently affixed compartment in the refrigerator.  In an interview on April 9, 2025, at 10:20 a.m., the Director of Nursing stated that the controlled medications should have been locked within a separate, locked, and permanently affixed compartment of the refrigerator.  28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0761			



# Certified End Page

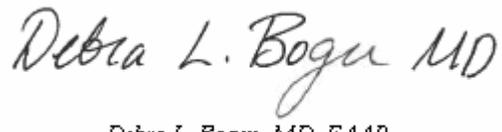
**POTTSTOWN SKILLED NURSING AND REHABILITATION CENTER**

**STATE LICENSE NUMBER: 380402**

**SURVEY EXIT DATE: 04/10/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY